

REPORT AND
RECOMMENDATIONS
TO THE CONGRESS
MARCH 1, 1996

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PROSPECTIVE PAYMENT
ASSESSMENT COMMISSION

REPORT AND
RECOMMENDATIONS
TO THE CONGRESS
MARCH 1, 1996



PROSPECTIVE PAYMENT ASSESSMENT COMMISSION

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The Prospective Payment Assessment Commission, created in 1983 by the legislation that established the Medicare prospective payment system for inpatient hospital services, advises the Congress and the Secretary of Health and Human Services on policies affecting Medicare payments to hospitals and other facilities. The Commission also studies industrywide effects of Medicare policies and important trends in the health care delivery system. On March 1 of each year, the Commission submits a report to the Congress with recommendations for improvements in Medicare policies and related subjects.

Prospective Payment Assessment Commission



300 7th Street, S.W.
Suite 301B
Washington, D.C.
20024
Tel (202) 401-8986
Fax (202) 401-8739

March 1, 1996

The Honorable Albert Gore, Jr.
President of the Senate
United States Senate
Washington, D.C. 20510

Dear Mr. President:

I am hereby transmitting to the Congress the annual report of the Prospective Payment Assessment Commission as required by Section 1886(e)(3) of the Social Security Act as amended by Public Law 101-508. This report presents a discussion of health care spending and its impact on the Medicare program, as well as major reforms proposed for Medicare. In addition, 26 recommendations concerning Medicare payment policies are included. The report reflects the Commission's judgment about issues of substantial importance to the Medicare program and beneficiaries, hospitals, and other providers.

Sincerely,

Stuart H. Altman, Ph.D.
Chairman

Enclosure

Prospective Payment Assessment Commission



300 7th Street, S.W.
Suite 301B
Washington, D.C.
20024
Tel (202) 401-8986
Fax (202) 401-8739

March 1, 1996

The Honorable Newt Gingrich
Speaker of the House
United States House of Representatives
Washington, D.C. 20515

Dear Mr. Speaker:

I am hereby transmitting to the Congress the annual report of the Prospective Payment Assessment Commission as required by Section 1886(e)(3) of the Social Security Act as amended by Public Law 101-508. This report presents a discussion of health care spending and its impact on the Medicare program, as well as major reforms proposed for Medicare. In addition, 26 recommendations concerning Medicare payment policies are included. The report reflects the Commission's judgment about issues of substantial importance to the Medicare program and beneficiaries, hospitals, and other providers.

Sincerely,

A handwritten signature in dark ink, appearing to read 'Stuart H. Altman', is written over a horizontal line. The signature is fluid and cursive.

Stuart H. Altman, Ph.D.
Chairman

Enclosure

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Executive Summary

Executive Summary

Since its inception in 1965, the Medicare program has provided health insurance coverage for the elderly and disabled. But this protection has come at a substantial cost to the Federal government. Between 1967 and 1993, total program expenditures climbed more than 30-fold. Medicare payments per person increased, on average, 8 percent annually over the same period. Total program spending reached an estimated \$177 billion in 1995, accounting for 12 percent of the Federal budget.

The rise in Medicare spending threatens the solvency of the program's Hospital Insurance Trust Fund, its primary source of income. Moreover, it has been a major contributor to the Federal budget deficit. Payment reforms have been implemented in the past to control spending and extend the solvency of the program. This year, the Congress has focused renewed attention on Medicare spending in its plan to balance the Federal budget by 2002. Both the Congress and the President have proposed Medicare savings that would be substantially greater than any previously achieved. Their proposals, however, reflect different views on the role of the Federal government in financing care for Medicare beneficiaries.

Both the Congress and the President would expand Medicare's reliance on capitation, because of its apparent success in slowing private sector health care spending. Under Medicare's capitation option, called the risk contracting program, Medicare makes an annual per capita payment to a contracting health plan to cover a defined set of services for enrolled beneficiaries. This shifts the responsibility for payment for covered services from the Federal government to the health plans. Medicare's spending for beneficiaries enrolled in the capitation program, therefore, is predictable and limited to the per capita payment. Further, health plans have incentives to manage service use and control their costs.

As currently designed, however, Medicare's risk contracting program does not fully realize the potential benefits associated with capitation. The program's per capita rates appear to be too high in

some markets, resulting in overpayment to plans, and too low in others, discouraging plan participation in those areas. To remedy this, the Congress and the President propose changing the payment rate setting method to generate more savings from the risk program and increase the number of plans available to beneficiaries. In addition, the Congress specifies annual increases to the capitation rates to reduce spending growth further.

Even with increased emphasis on capitation arrangements, the vast majority of Medicare services will continue to be purchased on a fee-for-service basis. Both the President and the Congress would make significant changes to Medicare's traditional fee-for-service payment methods and, in fact, would achieve most of their Medicare savings through this part of the program. In addition, the Congress would implement a savings enforcement tool called the "failsafe budget mechanism." For the first time in Medicare's history, total spending per enrollee in both the capitation and fee-for-service programs would be capped each year at a congressionally mandated amount, regardless of the number or types of services provided or the underlying rate of general inflation.

At the same time that these significant changes to Medicare are being considered, private sector financing and delivery of medical care are undergoing substantial changes. After years of rapid cost growth, underwritten by payment increases from private payers, hospitals are facing intense pressure to constrain their costs. They have successfully responded by holding cost growth below the level of inflation. As a group, hospitals have been able to maintain their financial condition. But some facilities, because of commitments to teaching or providing care to the poor, may be limited in their ability to continue to meet payer demands for constrained cost growth. Both the Congress and the President propose reductions to Medicare's teaching and disproportionate share adjustments. In light of these changes, the distribution of Medicare payments becomes more critical to ensure appropriate access and adequate quality of care for beneficiaries.

As hospitals have struggled to constrain their costs, the share of Medicare expenditures devoted to post-acute and ambulatory care providers has climbed. Medicare has imposed ever-tighter constraints on payments per service, but has failed to adequately address utilization. Volume control in these settings is particularly difficult because services can be provided in various sites. Payment constraints applied to one provider are likely to cause higher use in another. The Congress and the President begin to address this problem in two sectors with particularly high growth—skilled nursing facilities and home health agencies—by mandating prospective payment systems that bundle a set of services for a single payment.

The significant Medicare savings proposed by the Congress and the President, as well as Medicaid reforms and private sector cost-control efforts, will require health care providers to continue to modify their practices. In this dynamic environment, the challenge will be for Medicare to monitor the impact of these changes and appropriately adjust its policies to ensure continued protection of its beneficiaries.

RECOMMENDATIONS FOR FISCAL YEAR 1996

The Prospective Payment Assessment Commission (ProPAC) is responsible for advising the Congress and the Secretary of Health and Human Services on Medicare's payment policies for all health care facilities and their effects on beneficiaries and the facilities themselves. In addition, the Commission monitors important trends in the nation's health care system. In this report, ProPAC discusses the major reforms proposed for the Medicare program and the ramifications these might have for beneficiaries and providers alike. The Commission presents 26 recommendations covering a range of topics related to these reforms, in the context of promoting more efficient operation of the health care system while maintaining access to quality care for Medicare enrollees.

Recommendation 1: Slowing the Rise in Medicare Spending

The Commission supports the efforts of the Congress and the President to reduce the growth in Medicare expenditures. Over time, spending for

services furnished to Medicare enrollees should increase at rates comparable to those in a cost- and quality-conscious private sector.

Recommendation 2: The Failsafe Budget Mechanism

Any failsafe budget mechanism should include a more effective risk adjustment factor to ensure payment equity between the Medicare capitation and traditional fee-for-service programs. In addition, changes in inflation that differ substantially from CBO forecasts could require modifications to the Medicare benefit budget over time. Revisions to the proposed fee-for-service sector budget allocations could also be needed as medical practices change.

Recommendation 3: Expanding Medicare's Capitation Program

The Commission supports reforming the Medicare capitation program to control spending while expanding beneficiary choice.

Recommendation 4: Setting and Updating the Capitation Rates

Geographic variation in the capitation rates and the volatility of the rates from year to year should be reduced. The Secretary should develop and test alternative payment methods that would allow the payment rates to reflect changes in local market conditions.

Recommendation 5: Improving Risk Adjustment Methods

The risk adjustment methods used to set Medicare capitation payments should better reflect variation in the likely use of services. Even as research on the development of new methods continues, the Secretary should implement interim improvements as soon as possible.

Recommendation 6: Medical Savings Accounts

The Congress's high deductible/MSA option would provide an additional choice for Medicare enrollees. ProPAC is concerned, however, that the current Medicare risk adjustment method is not sufficient to protect the program from adverse selection and resulting excess spending. The likelihood that

rates would better reflect risk would be enhanced if Medicare enrollees were required to remain in the MSA option at least for several years.

Recommendation 7: The MedicarePlus Fee-for-Service Option

Enrollees choosing the fee-for-service option under the proposed MedicarePlus program could be responsible for substantially higher fees than what their plans would pay. The Secretary should monitor the impact of this option on beneficiary liability and on possible reductions in physician and other provider participation in traditional Medicare.

Recommendation 8: Information for Beneficiary Health Plan Choices

Medicare should make available to beneficiaries information about the performance of plans and local providers. The Secretary should identify the information beneficiaries need to make appropriate choices and develop innovative ways to improve access to it.

Recommendation 9: Health Plan Accountability

Medicare must hold health plans accountable for the appropriate use of Medicare funds. In addition, standards must be developed and enforced to ensure that Medicare beneficiaries will receive services of appropriate quality.

Recommendation 10: Updating PPS Operating Rates

ProPAC's update framework would support an update between 0.7 percentage points and 2.0 percentage points less than the increase in the hospital market basket index. The methodology employed by the Commission in previous years would lead to a recommendation of about market basket minus 1.5 percentage points, roughly corresponding to the midpoint of that range. In light of the significant changes occurring in health care delivery, the Commission believes that PPS payment rate increases could be held to market basket minus 2.0 percentage points for the next year or two. However, it is concerned about the potential effects of continuing updates at that level on hospitals' ability to provide quality care to Medicare beneficiaries and other populations.

Recommendation 11: Setting Capital Payment Rates

Prospective per discharge payment rates for inpatient capital costs should be set by developing an appropriate base payment rate and applying an annual update. The capital update should reflect the prices of capital assets, capital financing costs, and other factors related to the capital costs hospitals incur in efficiently providing inpatient care to Medicare beneficiaries.

Recommendation 12: Updating Payments to PPS-Excluded Hospitals and Distinct-Part Units

ProPAC's update framework would support an average update to the TEFRA target amounts equal to the projected increase in the market basket index minus 0.6 percentage points for fiscal year 1997. This average is within the range of facility-specific updates in the Congress's proposal, which is between the market basket increase and 2.5 percentage points below market basket. Major changes to the TEFRA target amounts should not be made at this time. Rather, a prospective payment system for PPS-excluded hospitals and distinct-part units should be implemented as soon as practicable.

Recommendation 13: Broadening Financial Support to Teaching Hospitals

Explicit financial support for graduate medical education activities should not be limited to the Medicare program. Mechanisms to broaden financial support for teaching-related activities in hospitals and other locations should be developed.

Recommendation 14: Medicare Payments for Graduate Medical Education Costs

ProPAC supports changes in Medicare teaching payments that would encourage an appropriate distribution of residents across specialties and discourage inappropriate growth in the total number of residents.

Recommendation 15: Medicare Indirect Medical Education Payments

The Medicare indirect medical education adjustment should be reduced from its current 7.7 percent level to 7.0 percent.

Recommendation 16: Distributing Additional Teaching-Related Payments

Funds that provide broader financial support for graduate medical education should be distributed in a way that corresponds to the additional costs incurred by teaching facilities. Providers that treat enrollees in capitation plans should receive teaching-related payments for those patients as well as for the other patients they serve.

Recommendation 17: Disproportionate Share Hospital Payments

The Commission is concerned about the potential impact of reductions in DSH payments. Hospitals that treat a large number of the uninsured could be particularly vulnerable because of recent changes in the health care environment. Large reductions in DSH payments would threaten the continued ability of many of these hospitals to serve populations who depend on them for access to care.

Recommendation 18: Method for Distributing Disproportionate Share Payments

The structure of the DSH adjustment should be reviewed to make certain that available funds are distributed equitably among the hospitals most in need of assistance. This may require collecting new data to develop a better measure of the services hospitals provide to indigent patients.

Recommendation 19: Discharges from PPS Hospitals to Other Facilities

Medicare payments should be modified to account for the shift in services from acute to post-acute settings. Broadening the definition of transfer cases, however, is not an appropriate approach.

Recommendation 20: Prospective Payment for Post-Acute Care

Prospective payment systems should be implemented for all post-acute services. The payment method for each service should be consistent across delivery sites. The Secretary should explore methods to control volume of post-acute service use, such as bundling services for a single payment.

Recommendation 21: Case-Mix Measures for Post-Acute Services

Reliable case-mix measurement is important in prospective payment systems to account for resource use and to analyze treatment patterns and costs across sites. The Secretary should coordinate case-mix research across post-acute care settings, using consistent methods for measuring patient acuity and resource use.

Recommendation 22: Interim Fee-for-Service Payment Method for Skilled Nursing Facility Services

An interim payment method should be implemented to control the growth in Medicare payments for SNF services until a comprehensive prospective payment system is established. A system based on historical data and facility-specific limits, however, may not allow facilities to respond appropriately to changes in a dynamic environment.

Recommendation 23: Interim Fee-for-Service Payment Method for Home Health Care

Until a fully prospective payment system is developed, the Commission supports adopting episode-based payment limits. In addition, beneficiary copayments, subject to an annual limit, should be introduced.

Recommendation 24: Update to the Composite Rate for Dialysis Services

The Secretary should develop methods to control total Medicare per capita expenditures for ESRD beneficiaries. In the meantime, the composite rate should be updated by 2.7 percent for hospital-based dialysis facilities and by 2.0 percent for freestanding facilities for fiscal year 1997. The Secretary should also develop reliable measures of patient severity and outcomes to analyze the relationships among treatment processes, patient outcomes, and costs. These factors should be considered in evaluating the need for and the level of future payment updates.

Recommendation 25: Prospective Payment for Hospital Outpatient Services

A comprehensive prospective payment system should be developed for hospital outpatient ser-

vices. Such a system should include a strategy for controlling the volume of ambulatory services.

Recommendation 26: Beneficiary Liability for Hospital Outpatient Services

The growing financial burden for Medicare enrollees who receive services in hospital outpatient

departments should be alleviated immediately. Beneficiary coinsurance for these services should be limited to 20 percent of the Medicare-allowed payment, as it is in other settings. For services not paid on a prospective basis, the Secretary should establish a new method for determining beneficiary copayments based on estimated allowed payments since they cannot be calculated precisely when services are delivered.

Chapter 1

Reforming the Medicare Program

Chapter 1

Reforming the Medicare Program

For 30 years, Medicare has fulfilled its promise of protecting the elderly, and subsequently the disabled, from financial impoverishment due to illness. This protection, however, has come at a substantial cost to the Federal government and taxpayers as well as to some Medicare beneficiaries. In 1967, the program covered 19.5 million people at a cost of \$4.8 billion.¹ By 1993, program spending had increased more than 30-fold to \$151.1 billion, with the number of enrollees almost doubling to 36.3 million. Medicare beneficiaries have felt the effects of the spending increases, with their cost-sharing responsibilities during 1993 exceeding \$30 billion.² Out-of-pocket costs for non-covered services also have climbed sharply.

Medicare program spending reached an estimated \$177 billion in fiscal year 1995, accounting for 12 percent of the Federal budget. The Congressional Budget Office (CBO) projects that, under current law, program spending will grow to \$332 billion by fiscal year 2002.³ Furthermore, the Federal share of Medicaid payments is expected to climb from \$89 billion to \$173 billion over this time. Consequently, spending for Medicare and Medicaid in 2002 is projected to consume more than one-fourth of the total Federal budget.

The rise in the cost of these entitlement programs is a major contributor to the projected growth in the Federal budget deficit. The relentless increases in Medicare spending for hospital, skilled nursing facility (SNF), home health, and other services also have led to the recent warning that Medicare's primary source of income, the Hospital Insurance (HI) Trust Fund, will not be able to cover anticipated expenses beginning in 2002.

This year, as it has periodically over the past 15 years, the Congress has taken steps to rein in the growth in Medicare spending, extend the solvency of the HI Trust Fund, and balance the Federal budget.

The reductions in spending growth now being considered by the Congress and the President, however, are substantially greater than those previously enacted. In addition, the proposal passed by the Congress—and vetoed by the President—embodies a major philosophical change in the role and responsibilities of the Federal government and the nature of the Medicare and Medicaid entitlements.⁴

The President supports the objectives of slowing the rise in Medicare spending, strengthening the financial integrity of the HI Trust Fund, and balancing the Federal budget. His approach, however, varies in fundamental ways from that of the Congress. The President's proposal reflects different budget priorities, allowing larger increases in Medicare and Medicaid spending and favoring smaller tax reductions.⁵ His approach also does not incorporate many structural changes to Medicare and Medicaid, such as those proposed by the Congress.

In this chapter of its annual report to the Congress, the Prospective Payment Assessment Commission (ProPAC) examines the Medicare and Medicaid spending trends that led the Congress to conclude that major reforms of these programs were necessary. Past Medicare expenditure patterns and projected spending through 2002 are described. The next sections review the impact of expenditure growth on beneficiaries' financial liabilities, the HI Trust Fund, and the Federal budget deficit. The steps considered by the Congress and the President to modify the Medicare program and slow the rise in spending are then discussed. The chapter concludes with the Commission's recommendations regarding reform of the Medicare program.

In Chapter 2, ProPAC describes and provides its views and recommendations to the Congress on the existing Medicare capitation option and the MedicarePlus program. This program would replace

Medicare's risk-based contracting policies. It also reflects substantial changes in the Congress's view of how Medicare's capitation program should operate. The next two chapters examine changes in the traditional Medicare fee-for-service program. Chapter 3 presents the Commission's recommendations regarding payment policies for inpatient hospital services. In Chapter 4, the rapidly growing areas of post-acute and ambulatory services are discussed, along with recommended changes to their payment policies.

HEALTH CARE SPENDING

Total national health care expenditures are expected to exceed \$1 trillion in 1995.⁶ The Federal government, the largest single payer for health care, will pay a third of the bill for medical services (see Table 1-1). The Medicare and Medicaid programs will account for \$346 billion of this spending, providing health coverage to 66 million people.

The responsibility for funding personal health care services has changed dramatically in the past 35 years, as government and private health insurance programs have expanded. Between 1960 and 1993, individual out-of-pocket spending rose from about \$13 billion to almost \$158 billion (see Table 1-2). As a share of personal health care spending, however, out-of-pocket expenditures declined from 56 percent to 20 percent, while private sector and government expenditures increased rapidly. Private sector expenditures climbed from about \$5 billion to \$288 billion. By 1993, the Federal government was spending

\$259 billion, about 33 percent of personal health care spending, primarily due to rapid expansion of the Medicare and Medicaid programs.

The enactment of Medicare and Medicaid in 1965 was followed by a rapid escalation in the health care portion of Federal, state, and local budgets (see Table 1-3). Health care expenditures increased from 7.6 percent of state and local government spending in 1965 to 12.4 percent in 1993. The effects on the Federal budget were more striking, with health expenditures rising from 3.9 percent to 18.6 percent of total Federal outlays over this period.

The drafters of the original Medicare legislation intended that the Federal government would provide most of the financing for care received by the elderly, but that services would be furnished through the existing private delivery system. The financing was to come primarily through payroll taxes, enrollee premiums and cost sharing, and general revenues. The Congress designed Medicare to pay for hospital and physician services without significantly altering the existing health care financing and delivery system.⁷ Thus, many of Medicare's payment policies were modeled after those in the private insurance market. The most important of these were the reliance on fee-for-service payment for physician services and cost-based reimbursement for hospital care.

These policies succeeded in guaranteeing needed care for Medicare beneficiaries. They also improved the financial condition of providers. But

Table 1-1. National Health Expenditures by Source of Funds, Selected Years

Year	In Billions of Dollars				As a Percentage of Total Expenditures			
	Private	Government		Total	Private	Government		Total
		Federal	State and Local			Federal	State and Local	
1965	\$ 31	\$ 5	\$ 5	\$ 42	75.3%	11.6%	13.2%	100%
1980	146	72	33	251	58.1	28.7	13.3	100
1985	259	123	52	434	59.7	28.4	11.9	100
1990	410	196	91	697	58.9	28.1	13.0	100
1993	496	281	107	884	56.1	31.7	12.1	100
1995*	552	334	121	1,008	54.8	33.2	12.0	100
2000*	770	528	174	1,472	52.3	35.8	11.8	100
2005*	1,051	821	247	2,119	49.6	38.8	11.6	100

Note: National health expenditures include all spending in the health care sector.

* Projected.

SOURCE: Congressional Budget Office.

**Table 1-2. Personal Health Care Expenditures by Source of Funds, Selected Years
(In Billions)**

Year	Total	Out-of-Pocket	Private	Government	
				Federal	State and Local
1960	\$ 23.9	\$ 13.4	\$ 5.4	\$ 2.1	\$ 3.0
1970	64.8	25.4	16.9	14.7	7.8
1980	220.1	61.3	71.8	63.4	23.6
1985	380.5	98.8	133.7	111.3	36.7
1990	612.4	138.3	230.7	178.1	65.3
1991	670.8	143.3	250.0	206.0	71.6
1992	729.7	150.6	269.8	234.0	75.3
1993	782.5	157.5	288.0	259.0	78.1

Note: Personal health care expenditures exclude research and construction, administration of public programs and net cost of private health insurance, and government public health activities.

SOURCE: Health Care Financing Administration, Office of the Actuary.

they greatly expanded service capacity and led to the rapid adoption of new and costly technologies, which contributed to the acceleration in Medicare expenditures.

Medicare Program Expenditures

In 1967—its first full year of operation—Medicare spent \$4.8 billion on behalf of its enrollees (see Table 1-4). Eligibility for the Medicare program was expanded in 1972 to people who were disabled as well as to those with end-stage renal disease. By 1980, spending had reached \$36.4 billion. Between 1980 and 1993, Medicare expenditures climbed on average more than 11 percent annually, to \$151.1 billion. Part of this rise can be

attributed to the growth in Medicare enrollees. From 1966 to 1993, the number of enrollees 65 or over rose about 2 percent a year and, since 1973, the number of disabled enrollees has gone up about 4 percent annually. The total Medicare-covered population expanded from 19.5 million in 1967 to 36.3 million in 1993.

In addition to the continuing increases in enrollees, the share of Medicare beneficiaries using services paid for by the program has risen sharply over the years. This has occurred partly because the growth in the Part B deductible has not kept pace with the rise in health care costs. Consequently, a growing number of beneficiaries meet the deductible requirements. Only 37 percent of enrollees, about 7 million people, had Medicare payments made on their behalf in 1967. By 1980, 18 million enrollees were being served, representing 63 percent of the Medicare population. In 1993 about 80 percent of the Medicare population, 29 million enrollees, used services paid for by the program. It is not surprising, therefore, that Medicare spending has increased. But this does not tell the full story.

Medicare program payments for each person served also have escalated at a rapid pace, from \$593 in 1967 to \$4,387 in 1993—an 8 percent average annual rate of increase.⁸ This rise is substantially larger than can be explained by general inflation during this time. In part, the growth in payments per person reflects medical inflation above that in the general economy. More important, however, are the continuing increases in the number and complexity of services furnished to Medicare beneficiaries.

Table 1-3. Government Health Expenditures as a Percentage of Total Government Expenditures, Selected Years

Year	Federal	State and Local
1960	3.1%	7.8%
1965	3.9	7.6
1966	5.2	7.5
1967	7.3	7.6
1970	8.5	7.8
1975	10.0	8.5
1980	11.7	9.9
1985	12.7	11.0
1990	15.4	12.9
1991	16.9	12.8
1992	17.4	12.6
1993	18.6	12.4

SOURCE: Health Care Financing Administration, Office of the Actuary and Office of National Health Statistics; and Department of Commerce, Bureau of Economic Analysis.

Table 1-4. Personal Health Care Expenditures Under Medicare and Medicaid, Selected Years

Year	Medicare		Medicaid	
	Spending (In Billions)	Enrollees (In Millions)	Spending* (In Billions)	Recipients (In Millions)
1967	\$ 4.8	19.5	\$ 3.0	—
1970	7.3	20.5	5.1	—
1973	10.2	23.5	9.1	19.6
1980	36.4	28.5	24.8	21.6
1985	70.3	31.1	39.2	21.8
1990	109.6	34.2	71.7	25.3
1993	151.1	36.3	112.8	33.4

* Includes Federal and state shares.

SOURCE: Health Care Financing Administration, Office of the Actuary.

Changes in Medicare policies will have different effects on beneficiaries, since a relatively small number of them account for a large portion of expenditures. In 1993, 53 percent had payments of less than \$500 made on their behalf.⁹ By contrast, 10 percent had payments of \$10,000 or more, representing almost three-quarters of all Medicare program spending. Slightly more than 3 percent had payments of \$25,000 or more; this group accounted for 39 percent of all spending.

Medicaid Program Expenditures

Medicaid is a joint Federal and state program intended to provide medical care to low-income people who meet certain requirements. States are given substantial flexibility, within Federal guidelines, to determine eligibility and benefits for their residents. Consequently, eligibility, coverage, and payment rules vary greatly among the states. Medicare enrollees are eligible for Medicaid if they meet the income and asset standards set by a state. About 12 percent of the Medicare population was dually eligible for both programs in 1993. In addition, state Medicaid programs are required to pay Medicare premiums and cost-sharing amounts for certain low-income persons, called Qualified Medicare Beneficiaries.

The Medicaid program has experienced substantial growth, adding pressure to state and Federal budgets. Medicaid spending spiraled from \$3.0 billion in 1967 to \$112.8 billion in 1993. During the 1980s, Medicaid program spending growth was relatively stable. In the early 1990s, however, expenditures jumped, in large part because of

expansions in eligibility, states' use of provider tax and donation programs to increase Federal matching payments, and changes in legislation that allowed states to increase payments dramatically to certain hospitals serving a disproportionate share of low-income patients.

Though more than 70 percent of Medicaid recipients were children and low-income adults in 1993, they accounted for only 30 percent of Medicaid payments. About 15.5 million children—almost half of all Medicaid recipients—received covered services. These children, however, generated only 16 percent of Medicaid payments. By contrast, about 27 percent of Medicaid enrollees were aged, blind, or disabled. This group, which included many Medicare beneficiaries, accounted for nearly 70 percent of total Medicaid spending, much of which was for long-term nursing home care. Hence, the Medicaid program serves important needs for the low-income Medicare population.

MEDICARE BENEFICIARY COST SHARING

The rapid rise in the cost of medical services has increased the financial burden for many Medicare enrollees, especially those with limited incomes. Medicare beneficiaries generally are responsible for paying a certain amount of the bill for the services they receive, and as program spending has gone up, so have their liabilities. These cost-sharing responsibilities include the inpatient hospital deductible, coinsurance requirements, and balance billing payments to certain physicians whose charges are higher than the payment allowed by Medicare. Beneficiaries must also pay for all of Medicare's allowed amount for physician and other Part B services until they reach a certain deductible.

Between 1977 and 1993, beneficiary liability as a share of overall Medicare spending dropped modestly, from 18 percent to 15 percent. Total beneficiary out-of-pocket spending for services covered by Medicare, however, rose more than five-fold.¹⁰

Over time the pattern of cost sharing has changed, reflecting differences in the types of providers used and the costs of various services. The share of beneficiary out-of-pocket spending for

Part A services, especially hospital and SNF care, has accelerated. Part B liability, which accounted for about 76 percent of cost sharing in 1977, fell to about 67 percent in 1993. A major factor in this decline was the limit on balance billing that the Congress enacted as part of physician payment reform in 1989. In addition, the increase in the Part B deductible, from \$60 to \$100 during this time, lagged far behind the rise in program spending or general inflation. The decrease in the deductible as a portion of Part B liability, however, was offset by the substantial growth in the share of coinsurance payments.

The average yearly cost-sharing liability per Medicare enrollee went from \$174 in 1977 to \$626 in 1993. This figure hides large differences in payments among beneficiaries for Medicare-covered services. Almost 65 percent of enrollees incurred a liability of less than \$500 in 1992, but 6 percent were responsible for more than \$2,000 in out-of-pocket spending. A small group of beneficiaries, 1.7 percent, confronted payments of \$5,000 or more. Thus, for certain beneficiaries the financial protection from the costs of major illness offered by the Medicare program falls far short of the need.

In addition to these cost-sharing liabilities, Medicare beneficiaries are responsible for payment of the Part B premium if they elect this coverage, as almost all do. There also are substantial gaps in Medicare coverage for certain services (especially medications) that the elderly and disabled frequently require. Most Medicare beneficiaries must pay for these non-covered services directly or through private supplemental insurance.

To reduce the risk of significant out-of-pocket spending, about 75 percent of Medicare enrollees relied on private insurance to supplement their Medicare coverage in 1992. Another 12 percent were dually eligible for Medicaid, which provides financial assistance in meeting these extra costs. About 11 percent of Medicare enrollees had no supplemental coverage and were at full risk for cost-sharing expenses, while the rest were covered by other programs. The increase in out-of-pocket spending also may contribute to the growth in the number of beneficiaries who are choosing plans in Medicare's capitation program. Many of these plans require little or no cost sharing. They also frequently supplement their benefit

packages with services such as prescription drugs, which Medicare does not cover.

THE SOLVENCY OF THE MEDICARE TRUST FUNDS

The Medicare program is financed through a variety of mechanisms, with funding channeled through two trust funds. The primary source of income for the Hospital Insurance Trust Fund is a dedicated payroll tax, paid by employers, employees, and the self-employed. Although Medicare is an entitlement, this fund must be solvent to pay claims on behalf of beneficiaries receiving Part A services, because trust fund balances limit spending authority. If the trust fund became insolvent, Part A Medicare payments would be limited to the money that accrued to the fund from current payroll tax receipts.

By contrast, the Part B Supplementary Medical Insurance Trust Fund is financed primarily through general revenues and enrollee premiums. General revenues and premiums each contributed about 49 percent of the fund's income in 1972. By 1993, the general revenue share was 72 percent, with premiums adding 25 percent. Although spending from this fund has been growing rapidly, insolvency is not a problem since general revenues are required to cover expected outlays that exceed premiums and other receipts. The growth in Part B Medicare spending, therefore, increases the Federal budget and contributes to the deficit.

The trust funds' trustees issue an annual report projecting revenues and expenses and evaluating the actuarial condition of each fund. To arrive at their conclusions, the trustees make assumptions about the growth in taxable wages and salaries, future rates of inflation, the number and life expectancy of Medicare enrollees, and patterns of service use. They base their projections on current Medicare statutory authority. In their 1995 report, the trustees projected that the HI Trust Fund would begin to run a deficit in 1996 and would be insolvent in 2002, seven years from the release of the report.¹¹

While projections of trust fund insolvency are not a new occurrence, they have received much more attention this year. Since 1970, on several occasions the trustees have projected insolvency of

the HI Trust Fund within seven years (see Table 1-5). Their projections have not materialized, primarily because the Congress has taken action to avert the impending insolvency. In 1972, the Congress raised the Medicare payroll tax rates and increased the ceiling on the level of earnings to which the tax is applied. The Congress also has enacted many provisions intended to control Part A expenditures by curbing the growth in payments to hospitals and other providers. In 1983, the Congress enacted the Medicare prospective payment system (PPS) for inpatient hospital services and other initiatives intended to slow expenditure growth. Steps also were taken that year, and again in 1990 and 1993, to increase HI Trust Fund revenues.

Because Medicare has relied primarily on a fee-for-service payment system, initiatives to slow the rise in spending have focused on reducing the price that Medicare pays for each service furnished.

Table 1-5. Number of Years from Trustees' Projection Until Insolvency of the Hospital Insurance Trust Fund

Year of Trustees' Report	Year of Insolvency
1970	2
1971	2
1972	4
1973	None indicated
1974	None indicated
1975	About 20*
1976	About 15*
1977	About 10*
1978	12
1979	13
1980	14
1981	10
1982	5
1983	7
1984	7
1985	13
1986	10
1986 amended	12
1987	15
1988	17
1989	None indicated
1990	13
1991	14
1992	10
1993	6
1994	7
1995	7

* Projections for 1975, 1976, and 1977 put the dates of insolvency, respectively, in "the late 1990s," "the early 1990s," and "the late 1980s."

SOURCE: Henry J. Aaron and Robert D. Reischauer, "The Medicare Reform Debate: What Is the Next Step?" *Health Affairs*, Winter 1995.

These actions have had less effect on the overall program budget, as the number and complexity of services provided have burgeoned, perpetuating the rise in program expenditures.

HI Trust Fund solvency remains threatened over the long term, in spite of past efforts to shore up the fund temporarily and reductions in spending growth currently considered by the Congress and the President. This is because the ratio of workers paying Medicare taxes to Medicare enrollees is declining as the baby boom generation ages into Medicare.

MEDICARE, MEDICAID, AND THE FEDERAL BUDGET

The Congressional Budget Office estimates that total Federal revenues in fiscal year 1995 will reach almost \$1.36 trillion (see Table 1-6). Expected outlays will be just under \$1.52 trillion, resulting in a \$161 billion budget deficit for the year. The cumulative Federal debt, as a result of years of deficit spending, now stands at \$4.9 trillion. The 1995 deficit is the smallest since 1989, but CBO projects that it will rise steadily over the next decade if current budgetary policies remain unchanged.

Federal spending is divided into mandatory and discretionary categories. Interest on the national debt is treated separately. Defense, international affairs, transportation, and domestic programs such as biomedical research funding are examples of discretionary spending. This spending is subject to review in the annual appropriations process. In addition, under current law it is subject to spending limits through 1998. Consequently, total discretionary spending is controlled, and policy makers must make trade-offs among competing programs. CBO projects that total discretionary spending will decrease from 35 percent of total Federal outlays in 1996 to 30 percent in 2002, if the current spending limits expire in 1998 as scheduled.

By contrast, mandatory entitlement programs like Medicare and Medicaid are not subject to annual review, the appropriations process, or spending limits. In 1996, total mandatory spending will account for 55 percent of Federal outlays. CBO estimates that the share of mandatory expenditures will climb to 62 percent in 2002. Medicare

Table 1-6. Selected Congressional Budget Office Projections, Fiscal Years 1995-2002 (In Billions)

Budget Category	1995	1996	1997	1998	1999	2000	2001	2002
Total revenues	\$1,357	\$1,423	\$1,487	\$1,553	\$1,625	\$1,703	\$1,783	\$1,871
Total outlays	1,518	1,595	1,668	1,736	1,820	1,907	1,994	2,100
Deficit	161	172	182	183	195	204	211	228
Medicare ^a	177	196	216	236	258	281	305	332
Medicaid ^b	89	97	107	118	130	143	157	173

^a Mandatory outlays.^b Federal share of Medicaid payments.

SOURCE: Congressional Budget Office.

and Medicaid outlays will be responsible for 17 percent of Federal spending in 1996. Under current policies, these programs are expected to consume 27 percent of the Federal budget in 2002. CBO points to the rapid growth in Medicare and Medicaid spending as the major factor driving up its deficit projections.

The Congress, intent on eliminating the Federal deficit by 2002, has looked to mandatory spending—and especially the rapidly growing health entitlement programs—for substantial budget savings. The Congress can control Medicare spending by changing eligibility policies or reducing benefits. It also can require higher beneficiary cost sharing or raise taxes. These approaches are regarded as politically unattractive, however. Consequently, over the past decade as it struggled with the Federal deficit, the Congress has looked primarily to reductions in payments to providers as the method of slowing Medicare spending growth. The current proposals generally continue to follow that path.

RENEWED ACTION BY THE CONGRESS

In November 1994, the American public elected, for the first time in several decades, a Republican-controlled Congress. The 104th Congress began its work in early 1995, determined to balance the Federal budget by 2002. The first formal step in the process was the passage of a budget resolution for fiscal year 1996. The Congress laid out its spending priorities and identified the broad program areas that it would target to balance the budget by 2002. The legislative process requires an independent projection of baseline expenditures and an assessment of the savings that can be expected from congressional proposals.

The Congressional Budget Office is charged with these responsibilities.

CBO's spending baseline reflects assumptions regarding economic growth and the level of future spending under current laws. The December 1995 update of the baseline projected that the budget deficit would rise from \$161 billion in 1995 to \$228 billion in 2002. To reduce the deficit, it is necessary for the Congress to enact legislation containing budget savings. CBO credits a legislative proposal with savings if it will result in reductions from the forecasted baseline growth. Thus, savings may be achieved even if spending continues to rise.

Medicare Savings

CBO projects that under current law, Medicare outlays (before subtracting offsetting premium receipts) will rise from about \$177 billion in 1995 to almost \$332 billion in 2002, or 9.4 percent annually (see Table 1-7). As a major contributor to the deficit, the Medicare program was initially targeted by the Congress for \$270 billion in savings over the next seven years. Revised CBO baseline estimates, however, projected slower Medicare spending growth. Consequently, the estimate of the savings in the bill passed by the Congress fell to \$227 billion.¹² Under this proposal, Medicare expenditures would rise at an annual rate of 7.2 percent.

By contrast, the President's proposal would result in \$102 billion in total savings and an annual growth rate of 7.6 percent. A separate bill (H.R. 2530), supported by a coalition of members of the House of Representatives, contains \$153 billion in Medicare reductions. The coalition's proposal would result in Medicare mandatory spending increases of 7.5 percent annually.¹³

Table 1-7. Medicare and Medicaid Baseline Spending and Estimates Under Alternative Proposals, 1995-2002 (In Billions)

Proposal	Mandatory Outlays				Total Net	
	1995	1996	2002	Annual Increase 1995-2002	Outlays ^a 1996-2002	Savings ^a 1996-2002
Medicare:						
Baseline	\$177.4	\$196.4	\$331.8	9.4%	\$1,679.5	—
Congress ^b	177.4	192.9	288.6	7.2	1,452.8	\$226.7
President ^c	177.4	196.4	296.4	7.6	1,578.0	101.5
Coalition ^d	177.4	192.2	294.1	7.5	1,526.8	152.7
Republican offer ^e	177.4	196.4	292.0	7.4	1,511.5	168.0
President's budget ^f	—	—	—	—	1,555.3	124.2
Medicaid:						
Baseline	89.1	97.2	172.6	9.9	924.1	—
Congress ^b	89.1	97.1	127.4	5.2	791.4	132.7
President ^c	89.1	97.2	154.0	8.1	872.4	51.7
Coalition ^d	89.1	97.2	162.5	9.0	877.9	46.2

Note: Baseline spending and other estimates based on Congressional Budget Office December 1995 budget baseline.

^a Includes effect of premium increases.

^b H.R. 2491, the "Balanced Budget Act of 1995," passed by the Congress on November 20, 1995.

^c The "Balanced Budget Act of 1995 for Economic Growth and Fairness," released by the President on December 7, 1995.

^d H.R. 2530, the "coalition budget," introduced on October 25, 1995.

^e Republican offer presented to the President on January 5, 1996, as estimated by the House of Representatives, Budget Committee.

^f President's 1997 budget released on February 5, 1996, based on savings estimated by the Office of Management and Budget.

SOURCE: Congressional Budget Office; House of Representatives, Budget Committee; and Office of Management and Budget.

The Republican leadership in the Congress and the President have attempted to arrive at an agreement resolving the differences in their proposals. As part of their negotiations, the Republican leadership submitted an "offer" that would reduce the total savings in their plan from \$227 billion to \$168 billion. The President also has revised his proposal, increasing Medicare savings from \$102 billion to \$124 billion.

The annual increase in Medicare spending is similar in all the proposals, ranging from 7.2 percent to 7.6 percent. The variation in total savings, however, is much greater due to differences in the growth of Part B premiums among the proposals.

Medicaid Savings

Because of its substantial growth, the Medicaid program also is a target for spending reductions. CBO projects that the Federal share of this program will climb from roughly \$89 billion in 1995 to

nearly \$173 billion in 2002, an annual rate of 9.9 percent. The legislation passed by the Congress would slow this rate to 5.2 percent over the seven-year period, saving just under \$133 billion.

Medicaid spending under the President's proposal would increase, on average, 8.1 percent a year, saving almost \$52 billion. The coalition's approach is similar, leading to 9.0 percent annual growth and about \$46 billion in expenditure reductions.

The MedicarePlus Program

The Congress is especially interested in expanding Medicare's capitation program. This would achieve both of the Congress's primary goals: slowing Medicare entitlement spending and reducing government control over the program.

Under Medicare's existing capitation program, participating health maintenance organizations contract to provide all covered services for enrolled beneficiaries in return for a predetermined

monthly payment per enrollee. This arrangement shifts the responsibility for payment for individual services furnished to beneficiaries from the Federal government to private plans. The proposed MedicarePlus program would expand the variety of health plans available to Medicare enrollees. It also would sever the connection between the capitation amount and spending in the fee-for-service program. The annual update to the capitation rate would be set in law to achieve the Medicare spending level desired by the Congress. The Congress has also expressed its dissatisfaction with the current administration of the capitation program. Its proposal would move program management from the Health Care Financing Administration to another entity within the Department of Health and Human Services.

The MedicarePlus program would include a wide range of options that meet the desire of many members of the Congress to eliminate Federal government involvement in the care Medicare beneficiaries receive. Especially noteworthy are the options to allow beneficiaries to join a private fee-for-service program or to select a medical savings account. Both of these choices would represent a significant change in the responsibilities of the Medicare program.

The Traditional Fee-for-Service Program

The traditional fee-for-service program continues to account for most of Medicare's spending. Consequently, almost 70 percent of the savings in the congressional proposal comes from this program (see Table 1-8). The 1995 base year spending and the projected increases over the next seven years differ greatly across types of providers (see Table 1-9). The savings would be spread across hospitals, physicians, and other providers and suppliers generally in proportion to projected spending increases. The bill also would move payment for home health services from a cost to a prospective payment basis, create facility-specific payment limits for ancillary services furnished in skilled nursing facilities, and provide for a SNF prospective payment system beginning in fiscal year 1998. Although the proposal slows the growth in Medicare payments to teaching hospitals, it provides new funding from general revenues for a Teaching Hospital and Graduate Medical Education Trust Fund.

Table 1-8. Estimated Savings from the Congressional Proposal, by Category, 1996-2002 (In Billions)

Category	Estimated Savings
Fee-for-service:	
Inpatient hospital	\$ 64.7
Outpatient hospital and ambulatory	19.1
Physicians	12.6
Home health	17.0
Skilled nursing	10.0
Other services	19.0
Total fee-for-service	142.4
Failsafe	11.5
Part B premiums	54.2
MedicarePlus	18.6
Total	226.7

SOURCE: Congressional Budget Office.

A NEW PHILOSOPHY

The legislation agreed to by the Congress includes stronger controls than any previously enacted to ensure that spending for the care furnished to Medicare beneficiaries does not exceed specific targets. The effects of the proposal, however, could extend far beyond its budgetary impact. The approach represents a fundamental change in the nature of the Medicare program. The bill would take a major step in moving the Medicare program from open-ended spending for covered services to a predetermined annual government payment per enrollee. To meet its budget target, the Congress spelled out specific spending rates of increase per enrollee in the MedicarePlus program. As a result, spending for these enrollees would be predictable and controlled.

This is not now the case in the traditional fee-for-service program, which pays hospitals, physicians, and other providers for the care they furnish. The more care these providers give, the more they are paid. Consequently, even when Medicare controls the price it pays for each unit of service, its spending escalates as the number of services increases. The reductions in fee-for-service payment growth contained in the congressional proposal fall short of meeting the seven-year budget

Table 1-9. Selected Congressional Budget Office Medicare Spending Estimates, Fiscal Years 1995-2002

Category	1995	1996	1997	1998	1999	2000	2001	2002
Total mandatory (in billions)	\$177.4	\$196.4	\$215.9	\$236.4	\$258.1	\$280.7	\$305.3	\$331.8
Part A enrollment (in millions)	37.0	37.6	38.2	38.7	39.2	39.8	40.2	40.7
Part A benefits (in billions)	\$113.6	\$124.8	\$136.0	\$147.2	\$159.0	\$171.2	\$184.2	\$197.7
Hospitals	80.2	84.5	88.8	93.9	99.5	105.2	111.0	116.7
PPS hospitals	68.9	72.4	75.6	79.3	83.2	87.2	91.2	95.3
Indirect medical education	4.3	4.6	5.2	5.8	6.4	7.0	7.7	8.5
Graduate medical education*	1.9	2.1	2.3	2.5	2.7	2.8	3.0	3.2
Disproportionate share	3.4	3.5	3.6	3.8	3.9	4.1	4.3	4.4
Inpatient capital*	7.9	9.6	10.4	11.1	11.8	12.6	13.1	13.6
Home health	14.7	17.2	19.8	22.2	24.2	26.2	28.3	30.6
Skilled nursing facility	9.0	10.8	12.2	13.3	14.5	15.7	17.0	18.4
Part B enrollment (in millions)	35.7	36.3	36.8	37.2	37.7	38.1	38.5	39.0
Part B benefits (in billions)	\$ 63.5	\$ 71.2	\$ 79.6	\$ 88.9	\$ 98.7	\$109.1	\$120.8	\$133.8
Physicians	32.2	36.0	38.8	42.1	45.2	47.9	50.8	53.8
Hospital outpatient	10.6	12.1	13.7	15.5	17.6	19.8	22.4	25.2

Note: Based on December 1995 budget baseline.

* Includes PPS and other hospitals.

SOURCE: Congressional Budget Office.

target by \$11.5 billion (after offsetting premium increases); that is, if spending rises at CBO's projected rate, outlays would exceed the target by this much. To make certain that spending is not more than the predetermined annual amount for each Medicare enrollee in the fee-for-service program, the Congress would impose a method to enforce the budget limits.

THE FAILSAFE BUDGET MECHANISM

An important aspect of the bill passed by the Congress is a savings enforcement tool called the "failsafe budget mechanism." For the first time in Medicare's history, total spending per enrollee in both the capitation and fee-for-service programs would be capped each year at a congressionally mandated amount. Medicare would still make payments to providers on behalf of beneficiaries. But total Medicare spending would be the same, even if the number of services provided grew or the rate of inflation changed.

Medicare Benefit Budget and Budget Allotment

The failsafe mechanism contains a specific annual Medicare benefit budget for fiscal years 1996

through 2002. This budget reflects the spending levels contained in the Congress's proposal. It includes all Medicare benefit payments and would meet the congressional objective of reducing Medicare spending growth by \$227 billion through 2002.

After 2002, an update formula would be applied to the budget for the preceding year. This would result in 5 percent annual Medicare spending growth per enrollee after 2002, regardless of the rate of inflation or service use. This same annual growth rate per enrollee would apply to beneficiaries in both the fee-for-service and the Medicare-Plus programs.

Each year, the Secretary would estimate a Medicare budget allotment for the fee-for-service program by removing from the benefit budget projected payments under the MedicarePlus program. The resulting budget allotment would be used as the basis for the failsafe requirements.

Sector Allocation

The Medicare fee-for-service budget allotment would be allocated to each of nine sectors (such as inpatient hospital and home health services). For

fiscal year 1996, baseline projected spending for each sector would equal the sector's fiscal year 1995 expenditures inflated by the sector's annual growth rate, as defined in the legislation. In subsequent years, each sector's legislated growth rate would be applied to the prior year's baseline.

Beginning in fiscal year 1998, the Secretary would reduce payments for all services in any sector that exceeded its target. The payment reduction would be proportional to the amount by which the Secretary estimates spending would exceed the sector target. The percentage reductions would be the same for all services within a sector, but would likely differ across sectors. The Secretary also would be responsible for adjusting payments in all sectors to ensure that aggregate spending would be consistent with the overall fee-for-service budget allotment. In addition, there is authority for a "look-back" adjustment to reflect actual fee-for-service and MedicarePlus expenditures when final data become available. If the President submitted a proposal to revise the baseline annual growth rates for fee-for-service sectors, the Congress would have to consider it under an expedited procedure.

Impact on Fee-for-Service Spending

The bill passed by the Congress would require \$11.5 billion in failsafe payment reductions between 1998 and 2002, according to CBO estimates. The ability of fee-for-service providers to avoid triggering the failsafe reductions depends critically on the number and intensity of services they furnish. CBO's estimates of projected spending include assumptions about annual increases in the number and intensity of hospital and SNF admissions, physician visits, and other services. Thus, to avoid these additional reductions, providers would have to furnish fewer services than CBO estimated.

Inflation rates that exceed CBO projections also could trigger subsequent payment reductions. The benefit budget is spelled out in specific dollar amounts between 1996 and 2002. After that, the update formula is a fixed percentage plus growth in the number of Medicare enrollees. There is no mechanism to account for changes in inflation. Annual payment updates for fee-for-service providers, however, are generally linked to a mar-

ket basket that measures inflation. Substantial increases in inflation would increase payment updates but could subsequently cause large payment reductions. The failsafe budget mechanism would not sunset, although fee-for-service payment updates generally would return to a market basket increase after 2002. Consequently, failsafe reductions could occur even when inflation or the number of services rose slightly.

Fee-for-service providers would be at further risk if healthier Medicare beneficiaries enrolled in MedicarePlus, while sicker beneficiaries remained in the fee-for-service program. The methods Medicare uses to adjust capitation payments explain very little of the variation in expected enrollee spending. The expansion of capitation plan options (especially medical savings accounts) may encourage beneficiaries who expect to use less than the average amount of services to enroll. The failsafe mechanism does not provide for adjustments to growth rates if healthier enrollees select MedicarePlus, leaving costlier ones in the fee-for-service program.

CHANGES IN THE HEALTH CARE ENVIRONMENT

The proposed reform of the Medicare program comes at a time when private sector financing and delivery of medical care are undergoing substantial change. Employers and other buyers of insurance are demanding lower premiums. In response, third-party payers are moving from fee-for-service policies to capitation and other managed care methods to control their costs, while providers are grappling with stepped-up competition for patients. Competition has altered the way providers do business, with the price of services assuming increased importance.

The restructuring of the nation's health care delivery system already has had an impact. National health care expenditures rose about 6 percent in 1994, among the lowest rates in the past three decades. In addition, surveys of employer health care costs show premium increases at historic lows.

The recent reports of private sector success in checking medical care expenditure growth have not been overlooked by those in the Congress who are intent on shifting governmental activities to the private sector. During the debate on the congressional

proposal, many members indicated they thought that the private sector could manage Medicare beneficiaries' care more efficiently than the Federal government could. If this were so, they reasoned, Medicare spending growth could be moderated without adversely affecting the care beneficiaries receive.

Analysts differ, however, in their assessment of the relative success of the government and private payers in restraining the rise in spending. CBO estimates that in 1995, national health care expenditures grew by 6.8 percent. Private sector spending went up 5.5 percent, while Federal outlays rose 9.1 percent. But interpreting such findings is complicated by the lack of good information on the number and health status of enrollees, where they live, and the benefits and services they receive. Further, expenditure levels in prior years must be considered.

When real spending (removing the effects of inflation) per Medicare enrollee is compared with private health insurance spending per insured person, the findings are mixed (see Table 1-10). Between 1979 and 1983, the private sector appears to have outperformed Medicare. From 1983 to 1991, though, the pattern reversed as the Medicare program implemented policies to curb the rise in expenditures. Since 1991, Medicare spending per enrollee again has surged, while private insurance spending per insured person has risen more slowly. The private sector's improved performance likely is related to the rapid move to capitation in recent years. The Medicare

program, by contrast, continues to rely predominantly on traditional fee-for-service methods.

While the Medicare program has successfully kept the payment per unit of service furnished in check, it has not been able to control increases in service volume and intensity. The private sector has relied more heavily on capitation, which allows plans to control costs by actively negotiating the price they will pay providers and by managing the services their enrollees receive. There is disagreement on how long the recent private sector cost-control trends can be maintained. CBO projects that private spending growth will again begin to rise, reaching 6.9 percent annually by 2000. This increase is still substantially lower than CBO's forecast of growth in Federal government spending under current law.

The moderation in expenditure growth for public programs, together with restraints in private health care spending, will require providers to continue to change their traditional ways of doing business. Hospitals and other providers are positioning themselves to compete in a health care system where total resources will grow much less rapidly than they have for many decades. Consequently, providers strongly support the provisions in the congressional proposal allowing them to develop provider-sponsored networks to compete with health plans.

THE UNINSURED POPULATION

The Congress's plan for modifications in the Medicare and Medicaid entitlements coincides with a decline in the proportion of people receiving health insurance through the workplace. Currently, about 15 percent of the population, almost 40 million people, lack health insurance coverage.

The Medicaid program provides an important safety net for those who would otherwise be uninsured. CBO projects that the number of Medicaid recipients will increase from 35.4 million in 1995 to 43.6 million in 2002 under current law. Medicaid spending reductions and other policy changes in the Congress's proposal could slow this growth substantially, and perhaps actually reduce the number of people eligible for Medicaid. Hence, the proposal—together with a declining share of the population covered by private insurance—could leave millions more uninsured.

Table 1-10. Real Change in Medicare Spending Per Enrollee and Private Health Insurance Spending Per Insured Person, 1979-1993 (In Percent)

Spending Category	1979-1983	1983-1987	1987-1991	1991-1993
Personal health care				
Private insurance	6.3%	6.9%	5.2%	4.7%
Medicare	7.6	2.9	3.8	6.5
Hospital care				
Private insurance	4.8	2.5	3.8	4.4
Medicare	7.0	1.1	2.3	5.9
Physicians' services				
Private insurance	7.0	10.8	5.8	5.1
Medicare	8.8	7.4	2.7	0.3

SOURCE: ProPAC analysis of data from the Health Care Financing Administration, Office of the Actuary.

Many of the uninsured receive hospital and other medical services. Traditionally, third-party payers have subsidized much of the cost of this uncompensated care. Under the price-competitive health care system that the Congress and private payers are encouraging, however, providers may be unwilling or unable to continue to subsidize such care. In addition, the Congress has proposed reducing the funds the Medicare program has provided to hospitals that care for a disproportionate share of low-income patients. In view of these developments, the problems related to the rising number of uninsured will probably be exacerbated. At some point, they are likely to require further action by the Congress.

CONCLUSIONS AND RECOMMENDATIONS

The Congress and the President continue to attempt to resolve differences in their approaches to curbing the rise in Medicare and Medicaid expenditures, strengthening the HI Trust Fund, and balancing the Federal budget. This chapter concludes with the Commission's recommendations on Medicare spending and the failsafe mechanism in the Congress's proposal.

Recommendation 1: Slowing the Rise in Medicare Spending

The Commission supports the efforts of the Congress and the President to reduce the growth in Medicare expenditures. Over time, spending for services furnished to Medicare enrollees should increase at rates comparable to those in a cost- and quality-conscious private sector.

The continuing escalation in Medicare costs is a threat to the solvency of the HI Trust Fund, a major contributor to the Federal deficit, and a financial burden for many enrollees. In ProPAC's view, the growth in spending for medical care in a private sector with market forces that encourage cost containment is an appropriate benchmark for the Medicare program. Judgments regarding appropriate spending levels and rates of increase should be based on several years' experience to account for short-term factors that may create a misleading picture of the trends. In addition, spending growth should be compared on a per person basis and

should recognize the health care needs of an aging and disabled Medicare population.

There are major deficiencies, however, in the data currently used to compare and forecast Medicare and private sector spending growth. The Commission plans to examine available data and alternative methods that could be used to assess trends in Medicare and private health care expenditures and will share these with the Congress.

Recommendation 2: The Failsafe Budget Mechanism

Any failsafe budget mechanism should include a more effective risk adjustment factor to ensure payment equity between the Medicare capitation and traditional fee-for-service programs. In addition, changes in inflation that differ substantially from CBO forecasts could require modifications to the Medicare benefit budget over time. Revisions to the proposed fee-for-service sector budget allocations could also be needed as medical practices change.

The failsafe mechanism in the Congress's proposal would allocate a fixed benefit budget for Medicare's capitation and fee-for-service programs. However, the risk adjustment methods currently used in Medicare's risk contracting program are limited. (See Chapter 2, Recommendation 5.) The lack of a robust risk adjustment method may result in higher-than-intended capitation payments. Further, there is no mechanism to adjust the fee-for-service budget to account for increases in average patient complexity and severity of illness that are likely to result if healthier enrollees select Medicare's capitation program. Consequently, per enrollee capitation payments could be too high and fee-for-service payments too low.

The failsafe mechanism lacks a provision to adjust the benefit budget if general inflation differs notably from CBO's forecast. Future increases in per enrollee spending in both programs may require modifications to reflect changes in inflation. In addition, future allocations of spending across the fee-for-service sectors will be based on spending projections that do not reflect the impact of the proposed legislation. The failsafe mechanism thus could lead to payment inequities among

provider groups as patterns of care continue to change. Adjustments in sector budget allocations may be necessary over time to maintain access to quality care for Medicare beneficiaries.

Notes to Chapter 1

1. This figure reflects Medicare program payments, which include payments from Medicare for covered services, but not administrative costs or beneficiary cost-sharing amounts.
2. This figure includes beneficiary deductibles, copayments, and balance billing amounts, but not Part B premiums. See Prospective Payment Assessment Commission, *Medicare and the American Health Care System, Report to Congress*, June 1995, 67.
3. Congressional Budget Office estimates of baseline spending and projected savings, December 1995. CBO makes a distinction between mandatory outlays for benefit payments and discretionary outlays for administrative costs. The estimates cited here include mandatory but not discretionary outlays. They do not reflect offsetting premium receipts. Net Medicare outlays, which include mandatory plus discretionary outlays less premium receipts, are projected to increase from \$160 billion in 1995 to \$308 billion in 2002.
4. The Medicare provisions are in H.R. 2491, the "Balanced Budget Act of 1995," passed by the Congress on November 20, 1995. This legislation also is referred to as "the conference agreement." The specific provisions referred to are included in Title 8, entitled "The Medicare Preservation Act of 1995."
5. The Medicare provisions of the President's proposal are included in Title 11 of draft legislation, entitled the "Balanced Budget Act of 1995 for Economic Growth and Fairness." This proposal was released by the President on December 7, 1995. It has not been introduced in the Congress.
6. National health expenditures include all spending in the health care sector. Personal health care expenditures exclude research and construction, administration of public programs and net cost of private health insurance, and government public health activities.
7. Medicare Hospital Insurance, called Part A, finances inpatient hospital care, as well as skilled nursing facility, home health, and hospice care. Supplementary Medical Insurance, or Part B, pays for physician services; outpatient services furnished by hospitals, dialysis facilities, and other ambulatory providers; and durable medical equipment and supplies.
8. Health Care Financing Administration, *Medicare and Medicaid Statistical Supplement, 1995* (Washington, DC: U.S. Government Printing Office) 176.
9. *Ibid.*, 182.
10. *Ibid.*, 176.
11. Board of Trustees of the Federal Hospital Insurance Trust Fund, *1995 Annual Report* (Washington, DC).
12. The savings estimates in all the proposals include those resulting from reductions in the growth of Medicare mandatory outlays and, where applicable, premium increases.
13. The Medicare and Medicaid provisions of the proposal are in H.R. 2530, introduced on October 25, 1995. This proposal also is referred to as the "coalition budget" proposal.

Chapter 2

Medicare's Capitation Program

Medicare's Capitation Program

Adoption of capitation payment methods by employers and some state Medicaid programs is widely credited with reducing the growth in their health care spending. Under capitation, the payer makes a predetermined payment per enrollee to a health plan that agrees to cover a defined set of services over a specified period, regardless of the number, type, or cost of services enrollees actually use. This contrasts with the fee-for-service payment method, under which payment is made for each service rendered. Capitation allows the payer to budget for health care spending over a year and eliminates its risk of spending any more than is budgeted. Additionally, capitation gives plans a financial incentive to reduce health care costs.

Medicare's largest capitation program, called the risk contracting program, has some of the cost-containment characteristics of capitation. Yet various aspects of the program design prevent Medicare from fully realizing the benefits of this payment method. Both the Congress and the President have proposed expanding and modifying Medicare's use of capitation. The legislation recently passed by the Congress (H.R. 2491) would broaden the range of private plans that could participate and modify the calculation of capitation amounts to curb the growth in Medicare's spending. The President's proposal would alter and increase the size of the risk program, but would not fundamentally change the way capitation rates are determined.

Refinements to the risk contracting program could contribute to Medicare's cost-control efforts while expanding the health plan choices available to its beneficiaries. To accomplish this, improved risk adjustment methods should be implemented and technical changes made to the calculation of the capitation rates. Further, Medicare needs to act as beneficiaries' agent in providing health plan information and monitoring plan performance. This is critically important because of the financial incentive plans have to limit health care costs.

This chapter first reviews policy issues relating to the existing Medicare risk program. Next, it provides an overview of the Congress's and the President's proposals to change the program. It concludes with the Prospective Payment Assessment Commission's (ProPAC's) recommendations to the Congress about setting the capitation rates, adjusting for risk, offering different types of plans, disseminating information to beneficiaries, and holding plans accountable for the services they provide.

THE MEDICARE RISK PROGRAM

In 1985 Medicare implemented its risk contracting program, under which health maintenance organizations (HMOs) receive a full capitation payment. The risk program was intended to allow Medicare to enjoy some of the advantages of capitation arrangements with health plans, among them predictable spending and savings. Enrollees also gain because many plans cover additional benefits and have low cost-sharing requirements.

Medicare has not taken full advantage of capitation's potential for savings, however. The program's capitation rates appear to be too high in some markets and too low in others, discouraging plan participation. Further, it appears that healthier beneficiaries are likelier than others to enroll, and the payment rates do not adequately reflect this lower risk of illness. Thus, Medicare may pay more for beneficiaries in its risk program than it would have had they stayed in the fee-for-service program.

Capitation Rates

The level of Medicare's capitation rates is tied closely to the program's traditional fee-for-service spending experience in each county. The annual growth in these rates mirrors this experience as well. Because HMOs are expected to furnish services through their provider networks more economically than Medicare does under its fee-for-service program, Medicare pays 95 percent of the estimated

amount it would have spent under the traditional program. Medicare retains the other 5 percent as savings. If plan payments are higher than projected plan costs (which include allowed profits), these savings are returned to enrollees in the form of additional benefits. These include, for instance, paying for services Medicare does not cover or reducing cost sharing for Medicare-covered services.

Level, Growth, and Variation—Obtaining the full potential savings from capitation requires continuous interaction between payers and plans. Those that purchase coverage can realize one-time savings by moving from higher premium fee-for-service plans to lower premium plans that accept capitation. They may enjoy ongoing savings if they can use their purchasing power to negotiate favorable premium rates. Some purchasers (other than Medicare) negotiate formally with plans; others have more informal processes for holding down annual premium increases. Some purchasers limit their premium contribution so that enrollees (who pay the difference between the premium and the employer's contribution) are more likely to choose lower priced plans.

Current law does not allow Medicare to use any of these approaches to limit the growth in capitation rates. This is true despite evidence that many plans in the risk program furnish all Medicare-covered services at costs significantly below their capitation rate. In 1994, the average Medicare capitation payment was \$26 a month higher than plans' expected average costs of providing Medicare services to beneficiaries. In certain markets with the highest rates, this difference was even greater—more than \$110 per enrollee per month.¹ However, in those areas without Medicare risk contracts (and there are many) rates may be too low to induce plans to participate.

Because Medicare's capitation rates are tied to fee-for-service spending experience, the program does not use information about plans' costs to set its rates in a market. Even though Medicare receives this information, it cannot negotiate lower rates in areas where the rates are higher than plan costs. At the same time, in areas where no plans participate in the Medicare program, it cannot raise capitation rates even if they are too low to cover plans' anticipated costs.

The linking of capitation rates to fee-for-service spending at the county level leads to substantial variability in the rates across areas. Further, there have been significant changes in some of these rates from year to year. This has been a particular problem in rural counties, since spending fluctuations are driven by the experience of relatively few beneficiaries. The instability of Medicare's rates over time may have dissuaded plans from participating in the risk program in certain counties, even when they serve other purchasers there.

Risk Adjustment—Voluntary choice among health plans raises the likelihood of risk selection. Plans may have a mix of enrollees whose relative risk of incurring medical expenses does not represent the group of people covered by a particular purchaser. Plans that attract beneficiaries with lower-than-average risk are less likely to experience financial losses. This can occur either through enrollee or plan action, or both. For example, some plans will pay only for services furnished by limited networks of providers. Enrollees who are healthier, and thus lack longstanding relationships with providers, may be more willing to join plans that limit provider choice, resulting in favorable selection to these plans.

If, because of risk selection, the capitation rate is too high relative to the services used by its members, the plan profits at the purchaser's expense. If it is too low, the plan loses financially. For these reasons, there has been considerable interest in developing a risk adjustment method that would allow the capitation payments to reflect more accurately differences in the likely need to use services among individuals.

The variation in patterns of health care use and spending among individuals is explained by both systematic and random risk. Systematic risk reflects expenditure variation associated with measured characteristics, such as age, sex, or chronic conditions, that are predictably related to use. Random risk is variation not associated with measured characteristics. The distinction between systematic and random risk is important, because risk adjustment methods account only for sources of systematic variation. Research suggests that about one-fifth of the variation in annual health spending is systematic, while the rest is random.² If this is correct, then even the best risk adjustment method would not

explain about 80 percent of the variability in health expenditures across individuals.

Available risk adjustment methods have been unable to account for much of the systematic variation. When used to predict individual annual expenditures, basic demographic adjustments (such as those used for Medicare capitation rates) explain little of the overall variation in resource use across individuals. Self-reported health status measures do slightly better. Methods that use prior claims information are among the best predictors of use, but they still account only for about one-eighth of individual variation in annual health care spending.³

Evidence indicates that Medicare risk plans have enjoyed favorable selection not accounted for by the program's risk adjustment method.⁴ The risk adjustment method Medicare uses pays plans different amounts according to their enrollees' demographic and other characteristics (see Table 2-1). For example, the capitation rate for hospital and other facility services for an 85-year-old female eligible for both Medicare and Medicaid is twice the average capitation rate. This risk adjustment method does not account for differences in the likely need for services among beneficiaries with the same demographic characteristics.

Medicare's month-to-month disenrollment policy, intended to attract beneficiaries who otherwise would be unwilling to try a capitation arrangement,

may contribute to favorable risk selection for plans. Recent evidence indicates that those who disenroll from risk plans use a disproportionate number of certain types of services after they return to the fee-for-service program.⁵ This may be due to beneficiaries disenrolling from their plans to use providers or services available through fee-for-service Medicare.

Medicare may be benefiting from the rising proportion of beneficiaries in risk plans in some markets. This is because, as the risk program's share of enrollment grows, the mix of beneficiaries is more likely to reflect the general Medicare population, making risk plans less likely to experience favorable selection than they had in the past. Moreover, increases in the proportion of people enrolled in HMOs appear to influence medical practice patterns. Providers may adopt cost-conscious ways of delivering care that are encouraged by capitation even for their patients who are in fee-for-service plans.⁶

Enrollment and Plan Participation

The early years of the Medicare risk program were marked by declining plan participation and gradual growth in beneficiary enrollment (see Table 2-2). However, the number of risk contracts and program enrollment both rose in 1993, 1994, and 1995. More plans have joined the risk program as capitation has become more widespread in the employer insurance market. Increasingly, plans are competing for members and looking to Medicare as

Table 2-1. Selected Demographic Group Risk Adjustment Factors to the Medicare Capitated Risk Payment, 1995

Age Group	Female			
	Non-Medicaid Non-Working	Working Aged	Medicaid	Institutionalized
Part A				
65-69	0.55	0.30	0.85	1.50
70-74	0.70	0.40	1.10	1.80
75-79	0.85	0.50	1.40	2.05
80-84	1.05	0.70	1.65	2.05
85+	1.15	0.75	2.00	2.05
Part B				
65-69	0.70	0.35	1.05	1.50
70-74	0.85	0.50	1.15	1.65
75-79	0.95	0.70	1.25	1.65
80-84	0.95	0.75	1.25	1.65
85+	1.00	0.80	1.25	1.65

SOURCE: Health Care Financing Administration, Office of the Actuary.

Table 2-2. Medicare Risk Program Participation, 1990-1996

Year	Enrollees		Contracts
	Number (In Millions)	As a Percentage of Total Medicare Enrollment	
1990	1.2	3.5%	95
1991	1.3	3.7	85
1992	1.5	4.2	83
1993	1.7	4.7	90
1994	2.1	5.7	109
1995	2.9	7.7	154
1996	—	—	189

Note: Enrollment data are as of September each year; contract data are as of January each year.

SOURCE: Health Care Financing Administration, Office of the Actuary and Office of Managed Care.

a potential source. Further, some plans are entering markets that formerly had no Medicare risk options, thereby expanding beneficiaries' choices. Entrants to competitive Medicare markets are stimulating existing plans' marketing activities, which may attract additional enrollees.

Medicare is taking steps to expand the risk program even further. One is to distribute information about risk plans to beneficiaries. Except in some regions, Medicare has left information dissemination largely to plans, making it difficult for beneficiaries to compare their choices. The Health Care Financing Administration (HCFA), which administers the risk program, is planning a new initiative to produce comparative information on premiums and benefits offered by participating risk plans in 1996. In addition, Medicare's exclusive reliance on HMOs with a limited provider network may be preventing it from realizing the program's full potential. In 1995, HCFA developed guidelines for out-of-network provider options for Medicare contracting HMOs. The agency is also conducting a demonstration program to determine whether beneficiaries are interested in joining other types of plans.

Plan Accountability

In return for its payments, a plan provides a defined set of services to its members. This obligation is particularly important under capitation arrangements. Under fee-for-service payment methods, plans and providers usually profit when the payment and volume of services increase.

Capitation, by contrast, creates incentives to limit the number and the cost of health care services. Plans that keep costs below their capitation payments retain the balance—and thus gain from lowering costs. But such an incentive creates concerns about how costs are constrained. Ideally, plans and providers will reduce services of marginal value by developing more effective and efficient modes of care. On the other hand, they could lower costs by failing to provide needed services.

Although Medicare has the authority to hold risk plans to their contractual obligations, it collects limited information on the care plans provide.⁷ Most of the data relate to plans' ability to meet an array of contractual requirements and comply with policies and procedures. HCFA has been trying to update its evaluations of plans by participating in several private sector initiatives to develop plan performance measures. These include both the Foundation for Accountability and the National Committee for Quality Assurance's exploration of cost, quality, and access measures appropriate for Medicare risk enrollees.

PROPOSED CHANGES TO MEDICARE CAPITATION ARRANGEMENTS

The Congress and the Administration have developed proposals to reform the existing risk program. Both would change the payment rate setting method to generate more savings from the risk program and increase the range of plans available to beneficiaries. The Congress's proposed changes would greatly expand the types of plans that could accept Medicare capitation payments and would break the link between the capitation rates and fee-for-service spending.

The Congressional Proposal: MedicarePlus

The Congress has proposed replacing the risk program with an expanded capitation program, called MedicarePlus. This program would permit Medicare beneficiaries to select from a wider choice of health plans. Under MedicarePlus, the method for setting the capitation rate would be changed to reduce rates in areas where Medicare fee-for-service spending has been high and to increase rates where it has been low. Growth in the rates would no longer be tied to increases in spending under traditional fee-for-service Medicare.

Changes to the payment method are designed to allow MedicarePlus to produce savings for Medicare. Whether or not the savings materialize, however, total program spending (for both Medicare-Plus and the traditional fee-for-service program) would be limited by the combination of the legislated rates and a budgeting tool called the “failsafe mechanism.” (See Chapter 1.) This mechanism would automatically impose additional payment reductions on providers in traditional Medicare if spending exceeded preset expenditure targets.

Plan Choices—MedicarePlus would allow a broad array of managed care plans, including preferred provider organizations (PPOs), to participate. Fee-for-service plans also would be permitted. New options not widely available in the private market, such as medical savings accounts (MSAs) and provider-sponsored networks, also could be offered to beneficiaries. All MedicarePlus plans would receive a capitation payment from Medicare.

This menu of plans would give Medicare beneficiaries more choices. Conceivably, they could choose any type of plan that met Medicare standards and that was open for enrollment in their area. Plans would be granted flexibility in product design and benefits, beyond Medicare-covered services. States would have a prominent role in monitoring product offerings under MedicarePlus.

Fee-for-Service Option—The Congress’s proposal defines MedicarePlus fee-for-service plans as insurers that “reimburse hospitals, physicians, and other providers on the basis of a privately determined fee schedule or other basis.”⁸ These plans would be required to pay non-contracting providers at least as much as the providers were paid in the traditional fee-for-service Medicare program. If these providers’ fees were higher than the plan’s payments, they would be permitted to bill Medicare beneficiaries for the difference.

Medical Savings Accounts—One choice in the congressional proposal would combine a high deductible insurance policy with a medical savings account. The MSA is a designated account to which Medicare would make an annual contribution and from which the beneficiary could draw for medical expenses. A beneficiary selecting this option would purchase a high deductible health insurance plan and receive the rest of his or her

Medicare capitation (less the price of the plan’s premium) in the form of a cash contribution to the MSA. High deductible plans would be required to cover all Medicare-approved expenses after the enrollee met a deductible of up to \$6,000.⁹ Beneficiaries could use MSA funds for any qualified medical expenses. They could also withdraw money from the account for non-medical spending (albeit with a tax penalty). Medicare beneficiaries in high deductible plans would not be permitted to buy insurance (other than long-term care insurance) to cover the cost of deductible expenses or additional services they might need.

MSAs are intended to make consumers bear more of the consequences of their choices to use health care services, while still offering catastrophic protection from the risk of a major expense. Supporters of MSAs believe they can lower the use of health services. They argue that if consumers had to pay the full price of medical care up to the deductible, they would make better decisions about the use of health care than they do when insurance masks the cost. A decline in the demand for medical services would drive down overall health expenditures directly by reducing utilization. Further, providers might respond to their patients’ price sensitivity by constraining their prices. Since Medicare would make a fixed payment, however, any savings resulting from using fewer services—at least in the short run—would go to the beneficiary and the high deductible plan, rather than to the program.

Beneficiaries electing this option would be strongly motivated to control their medical service use if they thought of the balance in their account as savings. If they took this view, spending from the account would seem the same as other spending. On the other hand, they might regard MSA funds as an account for health services.¹⁰ This would tend to reduce beneficiaries’ restraint in purchasing health services.¹¹ In any case, the lack of experience with this option makes it hard to predict how Medicare beneficiaries with MSAs would behave.

Most beneficiaries who selected the Medicare MSA option probably would benefit financially. Beneficiaries who did not anticipate using health services would be attracted to this option, because they would expect to keep unspent MSA funds.

Without adequate risk adjustment to the capitation rate, healthy beneficiaries choosing the MSA option could receive more funds from Medicare than the program would have spent had they remained in the traditional fee-for-service program. If this happened, Medicare expenditures would rise, increasing the likelihood that the failsafe mechanism would be triggered. Favorable selection into the MedicarePlus MSA option could thus result in reduced payments to traditional fee-for-service Medicare providers. Favorable selection may be exacerbated by beneficiaries' ability to opt out of this option every year. Because they can anticipate at least some of their medical expenses and can delay some treatments, beneficiaries could change to more comprehensive coverage when they needed it.

Not all beneficiaries selecting the high deductible/MSA option would be able to profit from their choice. They would risk significant out-of-pocket costs in the event of high spending. The financial risks would be especially great for enrollees in high deductible plans designed as fee-for-service arrangements, because providers' charges would not be limited to the amounts established by the traditional Medicare fee-for-service program. Thus, there would be only partial stop-loss protection for the beneficiary in these types of plans.

Providers might find they would incur more bad debt from treating patients with medical savings accounts, since they would need to collect payments directly from their patients. This would be particularly likely if beneficiaries depleted their MSA funds before reaching their deductible. In this situation, beneficiaries would be required to use their own money to pay for care.

Benefits—Under the MedicarePlus program, participating plans would provide, at a minimum, services covered under traditional Medicare. These services could be furnished through a managed care provider network, and plans could employ utilization management to determine medical necessity and appropriateness.

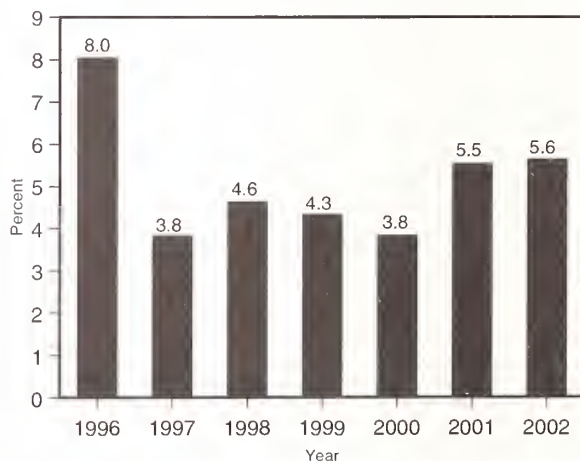
Plans would still be allowed to return the difference between their expected payments and costs to beneficiaries in the form of additional benefits. The Congress's proposal also would allow plans to

rebate this difference to beneficiaries in cash. As in the current risk program, these additional benefits could induce beneficiaries to enroll in Medicare-Plus plans. Plans thus would be able to compete with one another based on benefit package and provider network, as well as on price and beneficiaries' perception of plan quality.

As they do now, plans could charge beneficiaries premiums for supplemental benefits and for the actuarial value of whatever cost sharing beneficiaries would have incurred under the fee-for-service program. MedicarePlus plans would also be permitted to charge beneficiaries for the costs of covered Medicare services when the plans' estimated costs for these exceeded their MedicarePlus capitation payments.¹²

Payments to MedicarePlus Plans—The payment system under MedicarePlus is designed to allow savings to accrue to the Medicare program because the per person payment rates would be updated by legislated rates of increase (see Figure 2-1). These rates are below those currently projected for the Medicare program. As long as MedicarePlus enrollees were as likely to use services as other beneficiaries (or the risk adjustment method fully reflected differences in risk), the MedicarePlus program would reduce Medicare expenditures (see Table 2-3). Under these circumstances, savings from this component of Medicare would be driven by the number of beneficiaries

Figure 2-1. MedicarePlus National Average Growth Percentages, 1996-2002



Note: For all subsequent years the update is 5.0 percent.

SOURCE: H.R. 2491.

Table 2-3. Estimated MedicarePlus Enrollment, Savings, and Costs, 1996-2002

Year	MedicarePlus Enrollment (In Millions)	Percentage of Total Medicare Enrollment	Savings From Non-MSA Plans ^a (In Billions)	High Deductible/MSA Costs ^b (In Billions)	Total Savings (In Billions)
1996	3.0	8.0%	\$ -0.1	\$0.0	\$ -0.1
1997	3.8	10.0	-1.0	0.5	-0.5
1998	6.8	17.5	-1.8	0.6	-1.2
1999	7.7	19.5	-3.3	0.7	-2.6
2000	8.5	21.3	-5.8	0.8	-5.0
2001	9.3	23.2	-8.2	0.9	-7.3
2002	10.3	25.3	-11.3	1.1	-10.2
1996-2002	—	—	-31.4	4.6	-26.9

Note: The Congressional Budget Office constructed the capitation rates used in these estimates with Part A enrollment only. All capitation rates are expressed in calendar years. Numbers may not sum to total due to rounding. MSA = medical savings account.

^a Reflects savings from beneficiaries enrolled in non-MSA arrangements, including risk contractors.

^b The capitation rates and costs for new enrollees in high deductible/MSA plans reflect assumptions that these enrollees would be relatively young and would receive lower age-adjusted payments.

SOURCE: Congressional Budget Office.

who joined MedicarePlus plans. But if MedicarePlus experienced favorable selection (and risk adjustment did not correct for this), actual savings would be smaller than anticipated. Estimated savings from the MedicarePlus program would be somewhat reduced by anticipated costs due to enrollees in MedicarePlus high deductible/MSA arrangements. Regardless of the MedicarePlus enrollment or risk selection experience, however, overall Medicare spending targets would be achieved because of the failsafe budget mechanism.

Capitation rates under MedicarePlus would vary less across geographic areas than do rates in the current risk program. County rates would be blended with national ones, going up or down depending on the area's payment experience. Payment rate floors would further raise payments in areas where costs were especially low. Both the legislated updates and the blending would, in effect, uncouple the capitation amount from spending in traditional Medicare.

The MedicarePlus base payment rate would be the 1995 payment rates for risk plans in the existing program. Thus, the base rates would incorporate the geographic variation in service use patterns and health care prices as reflected in the 1995 rates. Each year, the Secretary of Health and Human Services would update these county-specific base rates using the legislated update factor for that year. Then, the Secretary would calculate the national

rate, which would be the average of all updated county rates weighted by the proportion of Medicare beneficiaries in each county.

The capitation rate for each county would be a blend of its own and the national rate. In 1996, 90 percent of payment would be the county rate. The national rate, adjusted for input price levels in that county, would account for the other 10 percent. Beginning in 1998, the blend proportion would be changed by 5 percentage points each year until the national rate made up 30 percent of the total. Finally, each county's blended rate would be compared with two payment rate floors. In 1996, each county's payment rate would be the highest of its blended rate, \$300, or 102 percent of the previous year's rate.

Blending the county with the national rate would reduce payments in areas with higher fee-for-service utilization and payments and boost payment rates in areas where use of services is lower. Plans could pass these gains to beneficiaries by providing additional benefits or cash rebates, or could retain them internally. Such flexibility could translate into increased plan participation and higher enrollment in areas where service use is lower. This payment method also would have the advantage of limiting the volatility of the rates, because the local and national components of the blend would be updated by a fixed national rate of increase specified in the law. Increases in payment rates in some areas,

however, would result in higher outlays under the MedicarePlus program than would be the case under the current payment system.

Risk Adjustment—The congressional proposal does not require the Secretary to modify Medicare's existing risk adjustment methodology, although the Secretary would have the authority to do so. Medicare's inadequate risk adjustment method would fail to account for risk selection differences among MedicarePlus plans. Nor would it fully reflect variation in use between those who enrolled in MedicarePlus and those who did not.

The limitations of the current risk adjustment method also have implications for spending in the traditional fee-for-service program. Suppose that a disproportionate number of healthier beneficiaries joined MedicarePlus, leaving the sicker and frailer in traditional Medicare. Then, fee-for-service spending per beneficiary would be higher, increasing any payment reductions in traditional Medicare required by the failsafe mechanism.

Enrollment and Disenrollment—MedicarePlus would discontinue month-to-month enrollment and disenrollment after a transition period. For each county, this period would start when the first plan was available for enrollment and end in October 1997. After this date, beneficiaries choosing to enroll in MedicarePlus would be locked into their plan for a year. They would still be able to drop out of a plan within 90 days of initial enrollment, or if they moved out of the plan's service area, or if the plan were found guilty of misconduct. Annual enrollment periods with a one-year lock-in provision could reduce favorable risk selection in MedicarePlus plans, increasing total savings and lowering the likelihood of payment reductions under the failsafe mechanism.

Beneficiaries generally would select MedicarePlus plans during annual open enrollment periods. The Congress's proposal would require the Secretary to conduct a coordinated information dissemination campaign before each open enrollment period. This could spur enrollment as beneficiaries learned about the MedicarePlus choices. On the other hand, eliminating the monthly disenrollment option might discourage reluctant beneficiaries from trying a MedicarePlus plan.

Accountability—The congressional proposal would strengthen current reporting standards and improve plan accountability by adding data reporting requirements similar to those that private purchasers impose. Beneficiaries would receive better information to compare MedicarePlus plans with each other and with the traditional program. Plans would report more specific information on factors that affect quality. An electronic data set would be established to provide uniform information on all participating plans. Many of the proposed requirements already exist in regulation. The proposal would strengthen these standards by putting them in statutory language, and would require more specific information to improve health plan accountability.

The Administration's Proposal

The President also has proposed expanding the risk program, but the changes would be less comprehensive than those the Congress has envisioned under MedicarePlus.¹³ Beneficiaries would be able to enroll in qualified PPOs and provider-sponsored organizations as well as HMOs. Most enrollees would be able to join one of these plans only during annual open enrollment periods. Private fee-for-service plans and high deductible plans combined with MSAs would not be among the available options. As an alternative to the full capitation payment, the Secretary would have the authority to pay plans using a partial capitation approach.

As in the existing risk program, participating plans would be required to cover, at a minimum, Medicare-covered services. Plans would have to demonstrate that the benefits they were providing, together with the premiums charged to enrollees, were at least actuarially equivalent to the benefits in the traditional Medicare program. Additional benefits offered by plans would have to conform to one of the standardized benefit packages the Secretary would design. Standardization would help beneficiaries evaluate price and benefit differences among plans.

The Administration's proposal addresses some shortcomings of the capitation rates in the current Medicare risk program. The proposal would limit variation in Part B payment rates (which cover physician services, medical supplies, and other outpatient treatment) across counties by raising those

that are low and capping those that have been inflated by high service use rates in the fee-for-service program. The annual growth in the rates, however, would continue to be linked to that in the fee-for-service program.

Other modifications would make the capitation rates more reflective of actual plan costs. Because fee-for-service claims are used to calculate Medicare's capitation rates, the rates include hospital payments for graduate medical education and for treating a disproportionate share of low-income patients. Plans that receive capitation payments may not incur such costs. The proposal would reduce capitation amounts to reflect these hospital payments, and Medicare would retain 25 percent of the amount saved. The rest would be distributed to both Medicare risk plans that contracted with academic medical centers and the academic medical centers themselves. This change in methodology would reduce the variation in the rates, since areas where beneficiaries in fee-for-service Medicare use teaching and disproportionate share hospitals generally have higher capitation rates.

A partial capitation approach would also be introduced. Plans would be paid using fee-for-service methods, but the amounts would be lowered 5 percent on each claim. At the end of the year, plans' per person payments would be compared with the capitation rate. Plans that had kept their spending below the targets would be rewarded with additional payments; those that had exceeded the targets would be required to return some of the excess to Medicare.

In the Administration's proposal, beneficiaries could enroll in plans under three circumstances only: during an annual open enrollment period, when they first became eligible for Medicare coverage, or when their plan opted out of Medicare. Beneficiaries could continue to disenroll from plans on a monthly basis. The Secretary would be directed to distribute comparative plan information to beneficiaries.

CONCLUSIONS AND RECOMMENDATIONS

Both the Congress and the Administration have proposed changes to Medicare's capitation program to address some of its shortcomings. The Congress

would go further in expanding beneficiary choices and modifying the payment method. In addition, it would create a link between the capitation program savings and payment rates in Medicare's traditional fee-for-service program through the failsafe budget mechanism. This chapter concludes with ProPAC's recommendations for improving Medicare's risk program as well as the Congress's and the Administration's proposals to change it.

Recommendation 3: Expanding Medicare's Capitation Program

The Commission supports reforming the Medicare capitation program to control spending while expanding beneficiary choice.

The Congress and the President have proposed ways to expand the role of capitation under Medicare. Capitation contains incentives for plans to control the cost and volume of the services they furnish. Further, such methods limit Medicare outlays to the per capita amounts.

Medicare beneficiaries should have a wider range of health plan options. Under the current program, beneficiary choice is largely limited to the traditional fee-for-service program and, where available, an HMO option. Additional alternatives would let Medicare beneficiaries choose the type of plan that best meets their needs and would permit new beneficiaries enrolled in a particular type of plan before retirement to stay in that arrangement. In addition, more alternatives could increase plan competition for Medicare beneficiaries on the basis of additional benefits and quality.

Recommendation 4: Setting and Updating the Capitation Rates

Geographic variation in the capitation rates and the volatility of the rates from year to year should be reduced. The Secretary should develop and test alternative payment methods that would allow the payment rates to reflect changes in local market conditions.

Medicare sets a capitation rate for each county based on its historical spending for resident beneficiaries in the traditional Medicare fee-for-service

program. The direct linkage to fee-for-service spending patterns in narrowly defined payment areas has led to substantial variability in the payment rates among counties and excessive annual changes in the rates for many areas. Private plans have been discouraged from participating in the risk program in areas with low capitation rates, as well as in those that have experienced high rate volatility. At the same time, risk plans located in counties with high capitation rates often have been paid substantially more than their actual costs of providing basic program benefits to Medicare beneficiaries. Further, since changes in rates and in local fee-for-service spending are linked, the Medicare risk program generally has not achieved the cost savings attained by private health plans.

The Congress proposes to reduce the geographic variability of the rates. It would do so by blending the local historical fee-for-service spending experience with the input price-adjusted national average and by setting payment rate floors. The annual volatility of the payment rates would be lowered by updating them with legislated growth factors. The President's proposal would decrease variability by removing special payments from the rates and by setting ceilings and floors on a portion of the payment rates. The President's proposal would have only a limited impact on volatility in the rates over time.

Neither proposal would allow the rates to vary with changes in the costs faced by plans. ProPAC believes alternative payment methods should be developed and tested that would better reflect the evolution and impact of market forces in each area. To accomplish this, information would have to be collected on the cost performance of individual plans to enhance the Secretary's understanding of markets and lay the foundation for implementing alternative payment methods, such as competitive bidding. The Commission wishes to emphasize that these data are not intended to support restricting plan profits or other regulatory activities.

Recommendation 5: Improving Risk Adjustment Methods

The risk adjustment methods used to set Medicare capitation payments should better reflect variation in the likely use of services. Even as research on the development

of new methods continues, the Secretary should implement interim improvements as soon as possible.

Effective risk adjustment of payments to health plans participating in the Medicare program is crucial to prevent rewarding or penalizing plans unwarrantably. It is equally essential to ensure that the financial burden of caring for Medicare beneficiaries is allocated fairly between the capitation program and the traditional fee-for-service program. These issues will become even more important if the risk program is modified to expand beneficiaries' choices among plans and plan participation.

The current knowledge base is not adequate to support highly effective risk adjustment methods. Moreover, health risks and the variations in propensity to use health services may never be sufficiently understood to adjust fully for differences in expected spending among individuals. Nevertheless, the methods used in the Medicare risk program could be improved. For example, information about the presence of specific chronic conditions, such as certain types of cancer or heart disease, enhances predictions about future health care spending levels for individuals. The Secretary should implement marginal improvements rather than wait for potentially better methods that may not be developed for many years.

While continuing to support further research on risk adjustment methods, the Secretary should also evaluate other features of capitation program design that may contribute to the risk selection problem. Enrollment and disenrollment policies, for example, may further concentrate particular groups of beneficiaries in the capitation program or in certain plans. Other policies regarding reinsurance or partial capitation may protect plans from adverse selection. Given the likelihood of continuing limitations in risk adjustment methods, these kinds of policies may be especially important as a source of auxiliary protection against the impact of risk selection.

Recommendation 6: Medical Savings Accounts

The Congress's high deductible/MSA option would provide an additional choice for Medicare enrollees. ProPAC is concerned,

however, that the current Medicare risk adjustment method is not sufficient to protect the program from adverse selection and resulting excess spending. The likelihood that rates would better reflect risk would be enhanced if Medicare enrollees were required to remain in the MSA option at least for several years.

Medicare payments for beneficiaries choosing the high deductible/MSA option proposed by the Congress could be higher than the costs that would have been incurred if those beneficiaries had remained in the traditional program. This is particularly likely if risk adjustment methods are not improved or if longer participation requirements are not imposed. In fact, the Congressional Budget Office estimates that beneficiaries in this type of arrangement would cost the program \$4.6 billion between 1996 and 2002. These costs could trigger the failsafe mechanism in traditional Medicare.

The Secretary should move quickly to improve the risk adjustment method. In addition, further research on the high deductible/MSA option is needed to assess the effects of various plan designs and to improve this option over time. Issues requiring a closer look include the amount deposited in the MSA, the length of time before disenrollment is allowed, and the features of the high deductible plan.

Recommendation 7: The MedicarePlus Fee-for-Service Option

Enrollees choosing the fee-for-service option under the proposed MedicarePlus program could be responsible for substantially higher fees than what their plans would pay. The Secretary should monitor the impact of this option on beneficiary liability and on possible reductions in physician and other provider participation in traditional Medicare.

Current policies limit the amount that most providers can bill Medicare beneficiaries above Medicare's payment. ProPAC is concerned that beneficiaries who choose the MedicarePlus fee-for-service option will be subjected to unanticipated out-of-pocket liabilities. The Commission also is concerned about provider behavior resulting from

these arrangements: Some providers may decide not to see those with traditional Medicare coverage by limiting their practice to patients who can pay high charges. This phenomenon could limit access of Medicare beneficiaries—particularly those with low incomes.

Recommendation 8: Information for Beneficiary Health Plan Choices

Medicare should make available to beneficiaries information about the performance of plans and local providers. The Secretary should identify the information beneficiaries need to make appropriate choices and develop innovative ways to improve access to it.

The risk contracting program distributes only limited information to beneficiaries about plans. Soon, however, HCFA will expand the data it distributes to include plans' benefits and premiums. The Secretary should continue efforts to identify the information beneficiaries need to make informed health plan choices and the most appropriate format for it. This is even more critical as health plan choices are expanded for Medicare beneficiaries. The Secretary should explore initiatives that would, for example, measure the satisfaction of beneficiaries who used services, describe total benefits available in an area (including those covered under insurance policies offered as supplements to Medicare), and document performance of individual providers within a plan.

As the number of choices under Medicare increases either through the current program or expansions, private entities likely will begin distributing information about these choices to beneficiaries. Although this is appropriate, Medicare should not abandon its responsibility to ensure that beneficiaries receive unbiased, comparable, and reliable data.

Recommendation 9: Health Plan Accountability

Medicare must hold health plans accountable for the appropriate use of Medicare funds. In addition, standards must be developed and enforced to ensure that Medicare beneficiaries will receive services of appropriate quality.

Under capitation, a health plan arranges with providers for coverage of services. Health plans have an incentive to limit the types and number of services delivered to each member when they receive a capitation payment. As a purchaser, therefore, Medicare needs to be particularly vigilant in ensuring that plans meet their contractual obligations to provide appropriate care.

The Commission recognizes that HCFA is working with the private sector to develop measures of

health plan performance. These relate to patient satisfaction, plans' financial stability, and other factors. Efforts to date have shown promise, but they still have not succeeded in providing definitive information on service use or health outcomes. Ideally, Medicare should be able to evaluate plan performance through risk-adjusted outcomes measures. Additional resources most likely will be necessary to implement an evaluation program that incorporates these measures.

Notes to Chapter 2

1. Prospective Payment Assessment Commission and Physician Payment Review Commission, *Joint Report to the Congress on Medicare Managed Care* (Washington, DC: ProPAC and PPRC, 1995).
2. Joseph Newhouse and others, "Adjusting Capitation Rates Using Objective Health Measures and Prior Utilization," *Health Care Financing Review* 10(3): 41-54, Spring 1989.
3. Several studies have examined claims-based risk adjustment systems, which include ambulatory care groups (ACGs) and diagnostic cost groups (DCGs). ACGs classify claims based on diagnoses in ambulatory settings, or all settings combined, as well as age and other factors. DCGs classify by diagnosis and other variables from previous hospital inpatient stays.
4. Randall Brown and others, *The Medicare Risk Program for HMOs—Final Summary Report on Findings from the Evaluation* (Princeton, NJ: Mathematica Policy Research, February 18, 1993).
5. Physician Payment Review Commission, "Biased Selection and Medicare HMOs: Analysis of the 1989-1994 Experience," unpublished paper, December 1995.
6. Prospective Payment Assessment Commission, "Relationship Between AAPCC Payments and Medicare Risk Plan Costs," unpublished paper, April 1995.
7. General Accounting Office, *Medicare: Increased HMO Oversight Could Improve Quality and Access to Care* (Washington, DC: GAO, August 1995).
8. H.R. 2491, Title 8, Subtitle A, Section 8001.
9. Costs for Medicare-covered services would have to count toward the deductible. Plans would have the discretion to count supplemental services toward the deductible or cover them once the deductible was reached.
10. American Academy of Actuaries, *Medical Savings Accounts: Cost Implications and Design Issues*, Public Policy Monograph #1 (Washington, DC: American Academy of Actuaries, May 1995).
11. Joseph White, "Medical Savings Accounts: Fact vs. Fiction" (Washington, DC: Brookings Institution Occasional Papers).
12. This policy reflects a clarification to the language in H.R. 2491, which was ambiguous on this issue.
13. This description reflects the proposal released in December 1995. The President subsequently may have changed this proposal.

Chapter 3

Acute Care Hospital Payments

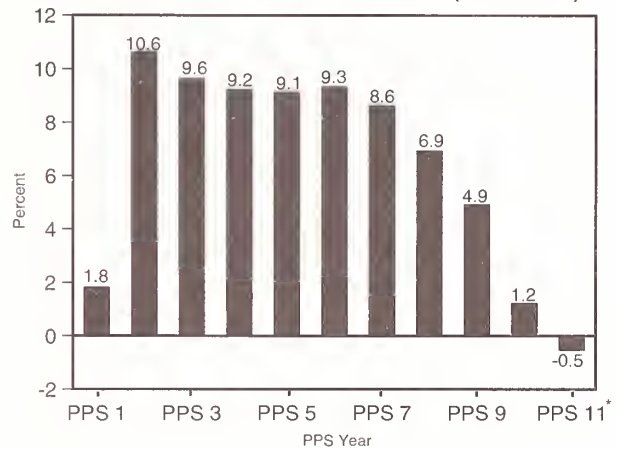
Acute Care Hospital Payments

Although both the Congress and the President propose to expand Medicare's use of capitation, most beneficiaries will likely remain in the traditional fee-for-service program for the foreseeable future. Based on this expectation, most of the proposed Medicare savings under either plan would be obtained through changes to the fee-for-service program. The majority of these savings would come from payments to acute care hospitals, including those paid under the prospective payment system (PPS) and those excluded from PPS.¹

Since its inception, the Prospective Payment Assessment Commission (ProPAC) has provided the Congress with recommendations on PPS payment updates, the structure of other PPS payment components, and the cost limits for PPS-excluded facilities. In fulfilling this responsibility, ProPAC considers the overall level of Medicare expenditures, the equity of payments across hospitals, and the adequacy of payments for ensuring appropriate quality of care. To support its decision making, the Commission examines not only hospitals' Medicare costs, payments, and margins for inpatient services, but also total margins and other indicators that reflect the larger environment in which hospitals operate. This information is used to develop ProPAC's recommendations, to evaluate the impact of payment policy changes, and to assess the need for further policy improvements. The data from recent years indicate that the hospital industry is changing in response to the incentives of PPS and the financial pressures imposed by other payers.

After nearly a decade of annual increases averaging around 9 percent per year, the growth in PPS operating costs per discharge began to moderate in the early 1990s. In 1992, the ninth year of PPS, the increase was down to 4.9 percent, and preliminary data for 1994 show that PPS costs per discharge actually decreased for the first time (see Figure 3-1). This 0.5 percent decline is more than 3 percentage points below the growth rate of the market

Figure 3-1. Annual Change in Medicare Operating Costs Per Discharge, First 11 Years of PPS (In Percent)



* Based on preliminary data and subject to revision

SOURCE: ProPAC analysis of Medicare Cost Report data from the Health Care Financing Administration.

basket index, which reflects the prices of goods and services that hospitals purchase.

The reduction in per unit cost growth in recent years has been much greater for inpatient care than for other hospital services like outpatient and skilled nursing care, due primarily to declines in length of stay. Moreover, the drop in length of stay has been steeper for aged patients (who make up the vast majority of the Medicare population) than for the non-aged—18 percent compared to 13 percent since 1989. The rapid fall of Medicare length of stay may partially reflect a trend toward discharging some patients to post-acute settings earlier in the course of their treatment, representing a change in the hospital product. This has led to concern about how Medicare pays for patients who are discharged from PPS hospitals to inpatient post-acute care providers.

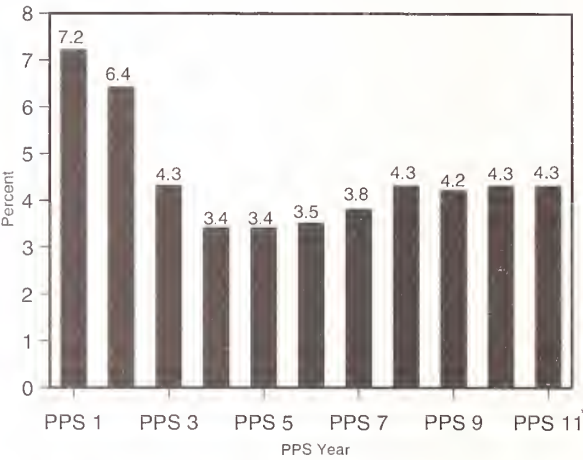
The substantial drop in hospital cost growth commonly is attributed to payers' resistance to continuing escalation in their payments. For a number of years, payment pressure was applied primarily by

Medicare and to some extent Medicaid. From the second through the eighth PPS years, the annual increase in Medicare payments per case was less than the corresponding per case cost increase, which resulted in steadily declining PPS margins (see Figure 3-2).²

During this period, hospitals generally were able to obtain the revenue they needed to cover additional losses from treating Medicare patients by cost shifting to private insurers.³ This was accomplished by obtaining payment increases from private payers that exceeded the corresponding cost increases. As a result, the average payment to cost ratio for private payers went from 116 percent in 1986 to 131 percent in 1992.⁴ Primarily because of cost shifting, hospitals were able to maintain fairly stable total margins, which reflect gains and losses from all payers as well as from non-patient care activities. Although the total margin for all community hospitals dipped by nearly a percentage point between the third and fourth years, it was back at 4.3 percent by the eighth year of PPS (see Figure 3-3).

In the early 1990s, more private insurers began to actively limit their payments to hospitals, and the combined pressure from public and private payers appears to have had a dramatic effect. In 1992, the ninth year of PPS, the Medicare per case cost and

Figure 3-3. Total Margins for All Hospitals, First 11 Years of PPS (In Percent)



* Based on preliminary data and subject to revision

SOURCE: ProPAC analysis of Medicare Cost Report data from the Health Care Financing Administration.

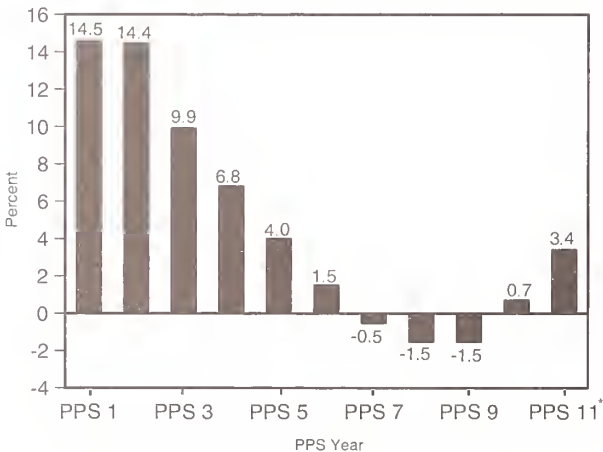
payment increases were the same. Over the next two years, despite payment increases as low as at any time since PPS began, cost increases that were even lower resulted in rising PPS margins.

During this period, Medicaid and uncompensated care losses stayed relatively stable. Consequently, hospitals were able to absorb smaller payment increases from private insurers without experiencing deterioration in overall financial status. The payment to cost ratio for private payers declined from its peak of 131 percent to 124 percent in 1994, while total margins remained virtually constant.

These trends portray a hospital industry adapting to an increasingly competitive environment. This has implications for how hospitals operate, how they interact with other types of facilities, and how accessible services are for Medicare beneficiaries and other populations. In the context of these changes, ProPAC presents the following discussion of payment issues and recommendations for improving Medicare policies.

The chapter begins by examining several payment update issues. Next, payments for teaching hospitals and facilities that treat low-income patients are addressed, followed by payments for discharges from PPS hospitals to inpatient post-acute providers. The chapter concludes with Commission recommendations in each of these areas.

Figure 3-2. PPS Margins for All Hospitals, First 11 Years of PPS (In Percent)



* Based on preliminary data and subject to revision

SOURCE: ProPAC analysis of Medicare Cost Report data from the Health Care Financing Administration.

All the payment components discussed are associated with provisions of the congressional or presidential proposals designed to reduce projected Medicare expenditures.

PAYMENT UPDATES

The Prospective Payment Assessment Commission is mandated by law to report to the Congress on the appropriate update to inpatient hospital payment rates under Medicare's PPS. In this section, the Commission discusses its views on updates to the PPS operating rates, PPS capital rates, and payments for PPS-excluded hospitals and units.

PPS Operating Rates

In developing and presenting its annual update recommendation for PPS operating rates, ProPAC uses a consistent framework to evaluate the likely impact of various factors that may affect hospital costs. These factors include hospital input price inflation, scientific and technological advances, productivity improvements, and changes in patient complexity. The Commission also looks at the potential impact of its decision on access and quality of care. The update recommendation traditionally has been for one year and for a specific rate of increase.

The Congress has proposed to set annual updates to PPS payment rates for fiscal years 1997 through 2002 at the market basket rate of increase minus 2.0 percentage points. By contrast, the President would set these increases at market basket minus 1.0 percentage points in fiscal years 1997 through 2000, and at market basket minus 1.5 percentage points in fiscal years 2001 and 2002. Recent experience suggests that actual per case payments will go up an additional percentage point each year due to changing patient acuity as measured by the case-mix index.

The Commission's update framework provides a foundation for evaluating these proposed updates. The framework begins with a forecast of hospital input price inflation in the coming year. This is based on a projection of the PPS hospital market basket index, which measures changes in the prices of a fixed basket of goods and services hospitals use as inputs to provide inpatient care. The market basket is also the basis for the annual hospital payment

updates set by the Congress. The most recent forecast of the market basket is an increase of 2.9 percent in fiscal year 1997, and slightly higher growth rates in later years.

The Commission's update framework also includes two adjustments related to the market basket. The first reflects differences between ProPAC and the Health Care Financing Administration (HCFA) in the construction of the index. ProPAC believes the index should equally reflect hospital industry wages and benefits and those in the economy as a whole. This requires giving more weight to the industry price proxies and less to general wages and benefits than HCFA does. Even so, the current forecasts for fiscal year 1997 yield the same result, 2.9 percent. If hospital wages and benefits continue to grow more slowly than compensation in the general economy—as they have recently—then future forecasts of ProPAC's market basket may be less than HCFA's.

The second adjustment is needed because the market basket forecast is subject to error. The Commission believes substantial forecast errors should be corrected when the actual market basket increase becomes available. The fiscal year 1995 payment rates were updated based on a market basket forecast of 3.6 percent. The actual increase, however, was 3.0 percent. This resulted in payment rates that were 0.6 percentage points too high, and this discrepancy should be removed in this year's update calculation. For the past few years, forecast errors have resulted in overstated payment rates, requiring later downward adjustments. This trend may last for another year or so. However, because the latest long-range market basket estimates are so low, future forecast errors might require a positive adjustment, especially if there is a resurgence of inflation.

The adjustment for scientific and technological advances is a future-oriented policy target intended to provide additional funds for hospitals to adopt quality-enhancing, cost-increasing health care innovations. The Commission has included adjustments ranging from 0.3 to 1.0 percentage points in past update recommendations. The current range likely is lower because there is little evidence of significant new cost-increasing advances ready for implementation. Moreover, the cost-competitive environment this industry now faces may dampen

the adoption of new technologies as hospitals closely evaluate their relative costs and benefits. A reasonable range for the increase in operating costs due to scientific and technological advances in 1997 is 0.1 to 0.6 percentage points. There is uncertainty about the appropriateness of this range for future years, however.

The productivity adjustment, also a future-oriented policy target, is intended to give hospitals an incentive to improve productivity. ProPAC generally expects hospitals to achieve productivity gains similar to those seen in the general economy. In the past, the Commission has expected productivity growth of anywhere from 0.5 percent to 2.0 percent per year. The adjustment in the update framework is intended to share productivity savings equally between hospitals and Medicare. The productivity adjustment thus has ranged from -0.3 to -1.0 percentage points. The near future might see even greater productivity improvements, as hospitals strive to stay competitive and financially viable. ProPAC's latest estimates indicate that hospital productivity increased as much as 2.3 percent in 1994. Given this improvement, a productivity adjustment in the range of -0.7 to -1.2 percentage points would be reasonable in fiscal year 1997.

Some of the apparent productivity improvements that have been observed may be due to hospitals shifting care traditionally provided in the hospital to other settings, such as skilled nursing facilities and rehabilitation hospitals and units. This site-of-care shift results in lower per case hospital costs, but not lower PPS payments. The update should reflect this site-of-care shift, which represents a change in the hospital product.

The final component in the Commission's traditional update framework is the case-mix adjustment. Under PPS, hospital payments go up automatically with increases in the case-mix index. But the case-mix index measures both real growth in patient complexity and growth due to coding improvements that are not associated with greater patient complexity. On the other hand, the index does not capture case-complexity changes within diagnosis-related groups (DRGs). Payment should reflect only real changes in patient complexity, in ProPAC's view. The case-mix adjustment in the update framework allows payments to

reflect both real across-DRG case-mix change and real within-DRG case-complexity change.

During the first few years of PPS, the national average case-mix index went up substantially, both because hospitals were coding more accurately and because patient complexity was increasing. This growth resulted in the need for rather large case-mix adjustments in the Commission's update framework, ranging from -0.7 to -1.0 percentage points. More recently, though, growth in the case-mix index has slowed, as hospitals' ability to improve their coding has diminished. This has led to smaller adjustments for case-mix change in the update framework over the past few years, ranging from -0.2 to 0.0 percentage points. The net effect of the case-mix adjustment on future updates is likely to remain small unless the DRGs are substantially revised.

Based on ProPAC's update framework, a payment update between market basket minus 2.0 and market basket minus 0.7 percentage points would be appropriate to compensate hospitals for expected cost growth for fiscal year 1997 (see Table 3-1). Moreover, substantial changes in health care financing and delivery in recent years should also be considered in setting an appropriate update. Hospitals face a more competitive environment as they vie for managed care contracts and patients. Further, private payers increasingly have resisted cost shifting, forcing hospitals to contain their costs to avoid deterioration in total margins. They have responded by holding their per case cost growth below the market basket increase. As a result, the aggregate PPS margin has increased and is now well above zero.

As a prudent purchaser, Medicare should respond to these changes by holding its price increases down and thereby sharing in the apparent productivity improvements hospitals are achieving. ProPAC's examination of the available data indicates Medicare should be able to keep its per case payment increase for PPS hospitals down to the market basket increase minus 2.0 percentage points for the next year or two without undue effects on the industry. After years of cost growth well above inflation, there should be substantial room for hospitals and the health care industry to generate lower rates of cost growth.

The Congress, however, proposes updates of market basket minus 2.0 percentage points for fiscal years 1997 through 2002. Maintaining such

**Table 3-1. Update Framework for PPS Hospital Operating Payments,
Fiscal Year 1997**

Components of the update

Fiscal year 1997 HCFA PPS market basket forecast	MB ^a
Adjustment for difference between HCFA and ProPAC market baskets	-0.1 to 0.0
Correction for fiscal year 1995 forecast error	-0.6
Allowance for scientific and technological advances	0.1 to 0.6
Adjustment for productivity	-1.2 to -0.7
Adjustments for case-mix change (fiscal year 1996)	
Total DRG case-mix index change	-1.0 to -0.9
Real across-DRG case-mix change	0.8 to 0.9
Within-DRG case-complexity change	0.0 to 0.2
Net adjustment for case-mix change	-0.2 to 0.0 ^b
Total PPS operating update	MB -2.0 to MB -0.7

Note: MB = market basket.

^a The most recent market basket forecast should be used to set the PPS update, which for fiscal year 1997 is 2.9 percent. This market basket forecast was provided by the Health Care Financing Administration, Office of the Actuary, December 1995.

^b The range for the net adjustment for case-mix change does not reflect the sum of the three case-mix change components, but rather was developed in consideration of those values.

updates throughout this period could have a severe impact on hospitals. The required restraint on cost growth may not be feasible or desirable. Low updates over an extended period could affect hospitals' financial health and compromise access and quality of care. They also could impede the diffusion of quality-enhancing technological advances.

PPS Capital Payment Rates

Since fiscal year 1992, Medicare has paid for its share of hospital capital costs, which consist primarily of interest and depreciation, using prospective per case rates. During a 10-year transition period ending in 2001, payments are based on a blend of hospital-specific rates and a single Federal rate.

Initially, the base Federal payment rate was set equal to the 1989 national average Medicare-allowable capital cost per discharge updated to 1992. Similarly, each facility's hospital-specific payment rate was its 1989 cost per discharge updated to 1992. From 1992 through 1995, HCFA updated base payment rates using a moving average of capital cost increases in previous years. During this period, however, the Congress required HCFA to adjust the payment rates in each year so that anticipated aggregate capital payments would equal 90 percent of anticipated aggregate costs. This budget

neutrality requirement meant that the effective payment rate was below the updated base payment rate in each year, with a growing discrepancy between the two. The expiration of budget neutrality at the end of September 1995 resulted in a 20.6 percent increase in the Federal capital payment rate for fiscal year 1996.

The congressional proposal would not alter the system for updating capital payment rates. However, it would continue the budget neutrality requirement through 2002 and lower payments to 85 percent of anticipated costs in each year. Thus, year-to-year increases in the effective capital payment rate would continue to be tied to changes in anticipated capital costs. Both the President and the Congress would reduce the Federal rate by 7.47 percent and the hospital-specific rates by 8.27 percent. These changes reflect information from hospitals' Medicare Cost Reports indicating that the 1992 base rates were overstated because the projection for cost growth between 1989 and 1992 was inaccurate.

ProPAC has recommended an alternative approach. An update framework, such as that developed by the Commission, would be applied to an appropriate base payment rate to determine the rate for the coming year. This would be similar to the method used to update PPS operating payment

rates and would finally break the link between aggregate capital costs and payments.

There are several ways to determine an appropriate base capital payment rate. For example, the 1995 effective rates—the prevailing payment amounts at that time—could be used as a base for future years. Hospitals have received these rates as capital reimbursement for the care of Medicare beneficiaries and appear not to have been adversely affected. Another method would be to rebase the 1992 capital payment rates as HCFA has suggested and update them to the current year using an analytic framework.

The ProPAC capital update framework is similar to the operating update framework described earlier. It includes factors for capital asset price changes (the capital market basket), forecast error correction, scientific and technological advances, productivity, and case-mix change. Some of these components have different values when applied to capital. ProPAC's framework also includes a discretionary financing policy adjustment for use in extended periods of unusually high or low interest rates. The application of such an update to an appropriate base payment rate would be part of a prospective payment system that provides incentives to hold costs down while recognizing the factors that determine capital cost increases for efficient hospitals.

Payments to PPS-Excluded Hospitals and Distinct-Part Units

Five types of hospitals (rehabilitation, psychiatric, long-term care, children's, and cancer) and two types of distinct-part units in general hospitals (rehabilitation and psychiatric) are exempt from PPS. These providers are excluded primarily because DRGs fail to predict their resource costs accurately.

PPS-excluded hospitals and distinct-part units are subject to the payment limitations and incentives established in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). Each provider is paid on the basis of its current Medicare-allowable inpatient operating costs per discharge relative to a target amount. Each provider's target amount is its allowable costs per discharge in a base year, trended to the current year by an annual update factor.

Medicare's share of allowable capital costs is paid in its entirety.

Under TEFRA, a facility with Medicare-allowable inpatient operating costs that are below its ceiling (its target amount times the number of Medicare discharges) receives its costs plus an incentive payment. This payment is equal to half the difference between its costs and ceiling or 5 percent of the ceiling, whichever is less. A facility with inpatient operating costs above its ceiling receives its ceiling plus half the difference between its ceiling and costs. Payments may not exceed 110 percent of the ceiling, however. Further, TEFRA provides an exceptions process whereby facilities may receive payment adjustments if their costs are unusually high due to extraordinary circumstances.

The update to the target amounts is set prospectively by statute. Under current law, facility-specific updates range from the forecast increase in the PPS-excluded market basket to the market basket increase minus 1.0 percentage points through fiscal year 1997. Facilities that had higher costs relative to their target amounts in fiscal year 1990 receive higher updates. In 1998 and beyond, all facilities would receive the full market basket increase.

The Congress initially excluded these hospitals and distinct-part units from PPS with the understanding that a separate prospective payment system would be applied at a later date. Such a system has not been implemented primarily because appropriate patient classification systems have not yet been developed.⁵ Nevertheless, interest in revising Medicare's payment system for these facilities persists owing to widespread concern about the long-term applicability of TEFRA.⁶ A major issue relates to payment disparities between new and old providers.

The use of historical costs to set target amounts systematically rewards providers that had relatively high base year costs. To the extent that these facilities restrain cost increases or lower their costs in subsequent years, they benefit by receiving incentive payments. By contrast, providers that had relatively low base year costs are penalized by having a low target amount. These facilities are less likely to benefit from incentive payments because they may be less able to realize additional efficiency gains in later years. Accordingly, the financial outcome for

the latter group becomes heavily dependent on the annual update to the target amount. The update also does not reflect certain factors that affect facility costs, such as changes in case mix or treatment patterns. Hence, target amounts are less likely to reflect the reasonable costs of providing services over time. Providers that have been subject to TEFRA longer, therefore, may be disadvantaged relative to new ones entering the market.

Recent ProPAC analyses suggest that, in aggregate, rehabilitation hospitals and distinct-part units have done well financially under TEFRA. For most other excluded facility types, though, aggregate operating payments are at or below aggregate operating costs. Further, substantial variation in the extent to which facilities' costs exceed their target amounts was found across and within all provider types.

Although aggregate Medicare payment to cost ratios generally improved for psychiatric, long-term care, and children's facilities in recent years, this was due primarily to the influx of new providers. Facilities that first received TEFRA payments after fiscal year 1989 had higher payments (as well as higher payments relative to costs) than facilities that were subject to TEFRA before 1990. Because it does not have data on exceptions payments, however, the Commission cannot draw definite conclusions about financial performance.⁷ Anecdotal evidence suggests that certain facilities, particularly long-term care hospitals, receive large lump-sum exceptions payments. Therefore, reported losses are likely to be overstated, but by how much is unknown.

Both the Congress's and the President's proposals contain provisions to mitigate the payment disparities between new and old providers as well as generate savings for the Medicare program. The Congress would apply a facility-specific update to the target amount ranging from the projected increase in the PPS-excluded market basket to the market basket increase minus 2.5 percentage points for fiscal years 1996 through 2002. The reduction from the market basket projection would depend on the extent to which a facility's current costs exceed its target—the higher a facility's costs are relative to its target, the larger the update. Facilities with allowable costs substantially below the ceiling in a given year would not receive an update. These low-cost providers generally would

receive the same incentive payment, however. The Congress also would reduce capital payments, which are based on each facility's Medicare-allowable costs, by 10 percent.

The Congress also proposes to apply a floor to the target amounts for rehabilitation facilities and long-term care hospitals that first received Medicare payments before October 1, 1995, and a ceiling for those that first received payments on or after that date. Further, a new base year would be assigned to certain long-term care hospitals that serve a disproportionate share of low-income patients and had costs above their targets in fiscal years 1993 and 1994.

The President proposes to update the TEFRA target amounts for all providers by the projected increase in the market basket minus 1.0 percentage points for fiscal years 1996 through 2000. In 2001 and 2002, the update would equal the market basket increase minus 1.5 percentage points. Further, facilities would receive 85 percent of their Medicare-allowable capital costs in fiscal years 1996 through 2005.

To account for the widening disparity between costs and payments for certain providers, the Administration proposes to rebase the target amounts for all PPS-excluded facilities using more recent cost report data, subject to floor and ceiling limits. The proposal also includes revisions to the basic TEFRA payment method such that only certain facilities would be eligible for exceptions adjustments. Additionally, only those providers whose costs exceed 110 percent of the target amount would receive payments greater than their target. Finally, the President would impose a moratorium on certification of new long-term care hospitals.

TEFRA modified cost-based payments to encourage providers to operate more efficiently and restrain cost increases. It is expected, therefore, that some facilities will be winners, while others will lose. But by its very design, TEFRA systematically creates an inequitable payment distribution. These inequities may be mitigated by the exceptions process, which provides additional payments to facilities when events or circumstances beyond their control significantly increase their costs. However, the potential availability of exceptions may weaken TEFRA's cost-containment incentives.

The Commission therefore believes that Medicare should move more quickly toward implementing a prospective payment system for these facilities. Such a system, in which payments are based on national or regional average costs rather than on facility-specific costs, would promote efficiency among providers. It also would recognize certain cost differences that are beyond providers' control and accommodate changes in case mix and practice patterns.

In the interim, ProPAC's analytic framework can be used to update TEFRA target amounts. This approach is similar to the Commission's framework for PPS payment updates, but modified to reflect differences between TEFRA and PPS. Hence, the update is determined primarily by the projected increase in the PPS-excluded market basket index.

Medicare automatically shares in savings from productivity improvements under the TEFRA system, and payments are not case-mix adjusted. Consequently, adjustments for these factors are not needed to determine an appropriate update. Scientific and technological advances, while considered, were not included because they are not likely to increase costs significantly in the coming year. Therefore, the Commission's methodology results in an update for fiscal year 1997 equal to the market basket increase minus 0.6 percentage points to account for previous forecast error.

Although this framework yields an average update for all PPS-excluded providers, the Commission supports the notion of a facility-specific update as contained in current law and in the congressional proposal. By allowing for differential updates depending on the costliness of care, such an update recognizes that, in some cases, rising costs may be beyond a hospital's control.

TEACHING HOSPITALS

Medicare is the only payer that makes explicit payments for hospitals' teaching-related costs: the indirect medical education (IME) adjustment and the direct graduate medical education (GME) payment. Other payers have traditionally paid higher rates to teaching institutions for these costs. The Congress and the President propose to make several changes to Medicare's payments. The Congress also would establish a Teaching Hospital and

Graduate Medical Education Trust Fund to provide additional explicit support for teaching-related costs.

Teaching hospitals incur higher costs than other facilities because of their education and research missions. Many carry the added financial burden of caring for a disproportionate share of poor or uninsured patients. Higher costs may put these facilities at a disadvantage relative to other hospitals, particularly in areas with excess inpatient capacity. Because Medicare provides additional funds to teaching and disproportionate share hospitals, the PPS margins for these facilities are much higher than those for other hospitals. Their total margins, however, are lower than average. The Commission is concerned about maintaining the financial viability of teaching hospitals because of the special role they play in the health care system.

These concerns are heightened by the changes now occurring in the health care marketplace. Teaching hospitals may have added difficulties obtaining patient volume or contracts from increasingly cost-conscious insurers and health plans. As these financial pressures grow, the Medicare program needs to ensure that its payments accurately account for the added costs teaching hospitals face. The appropriate role of other payers in supporting these social goals needs to be reassessed as well. It also is critical that funds be distributed to those facilities that make the largest contributions and have the greatest need.

The distribution of teaching-related payments can influence the number and mix of physicians across specialties. Medicare inpatient payments go up for each resident a hospital trains, which could provide incentives to substitute residents for other personnel. Further, certain specialties may be more attractive to hospitals because they can generate greater faculty practice plan revenues than others. These factors may distort the hospital market for residents and may impede movement toward an appropriate mix and number of physicians. The distribution of teaching-related funds therefore must encourage, or at least be consistent with, the right balance.

Both the Congress and the President would substantially reduce Medicare's teaching-related spending, with cumulative savings between fiscal

years 1996 and 2002 of almost \$13 billion under the congressional proposal and \$10 billion under the President's. The size of the Medicare teaching payment reductions would be the same under both proposals in fiscal year 2002: about \$3.2 billion, according to the Congressional Budget Office. The financial effects of these reductions, along with other changes in Medicare payment, need to be monitored to make sure they do not adversely affect teaching hospitals. The Medicare payment reductions in the congressional proposal would be offset, however, by general revenue payments from the new Teaching Hospital and Graduate Medical Education Trust Fund, whose cumulative contributions would total \$13.5 billion through fiscal year 2002.

Direct Graduate Medical Education Payments

When PPS was implemented, Medicare's share of the direct costs of residency training programs (salaries and benefits of residents and faculty, classroom costs, and associated overhead) was reimbursed on a reasonable cost basis. The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) changed this to a hospital-specific per resident payment amount based on reported costs from the first year of PPS. This amount is updated annually by the increase in the consumer price index, although the payment amounts were frozen for non-primary care residents in fiscal years 1994 and 1995. Medicare's payment is determined by multiplying a hospital's updated per resident payment amount by the weighted count of residents and then by Medicare's share of inpatient days. Residents who have completed their initial residency period are counted as half a full-time equivalent (FTE) resident. The initial residency period is the minimum number of years required for board eligibility in a specialty or five years, whichever is less.

One issue of concern is the wide variation in the per resident payment amounts across hospitals, caused by differences in reported base year costs. This variation may be the result of differences in resident salaries, teaching physician costs, or allocated overhead expenses. These base year cost differences, however, may also reflect variation in hospital cost reporting practices. Resident counts and the use of weighting factors to pay less for certain residents is another issue. Medicare does not

limit the number of residents who can be counted for payment, and there is concern that this may encourage hospitals to expand their training programs. Weighting factors are used in the current direct GME payment to discourage hospitals from training residents in subspecialties. It is unclear, though, whether the current weighting factors influence hospitals in their specialty mix decisions.

Medicare GME payments would remain unchanged under the congressional proposal, except that residents who are past their initial residency period would count only as a quarter of an FTE. In addition, the aggregate number of residents used in calculating payments would be frozen, although this would affect only hospitals that experienced an increase in residents.

The President's proposal would extend through fiscal year 2000 the freeze on per resident payment amounts for residents who are in non-primary care specialties. This proposal also would freeze, on a hospital-specific basis, both the number of non-primary care residents and the total number of residents who could be counted for payment. In addition, the Administration's proposal would allow direct GME payments to non-hospital providers for primary care residents in other settings when the hospital is not paying for the resident's salary in those sites.

Indirect Medical Education Payments

The indirect medical education adjustment is intended to compensate teaching hospitals for their higher Medicare patient care costs. These costs may be due to greater patient acuity, a broader scope of services available, more intensive treatment, and a costlier mix of staff than in other facilities. They may also be attributable to the expense of developing and improving diagnostic and therapeutic technologies or to the less efficient practice style of residents.

Since 1987, the indirect medical education adjustment to PPS operating payments has been set at 7.7 percent for every 10 percent increment of teaching intensity, as measured by the ratio of interns and residents to hospital beds. On the basis of several years of analysis, the Commission believes the technically appropriate rate is 4.5 percent. Recognizing, however, that a sharp reduction

in IME payments could seriously affect teaching institutions, ProPAC in 1995 recommended lowering the adjustment from 7.7 percent to 6.7 percent in fiscal year 1996 and making further reductions only after reviewing the financial effects of this change. This recommendation was made in the context of the payment provisions in effect at the time.

The Congress has proposed reducing the IME adjustment to 6.7 percent in fiscal year 1996. The adjustment would then continue to decline gradually each year to a final level of 5.0 percent in fiscal year 2000. In addition, the proposal would establish a medical education trust fund that would provide additional payments to teaching hospitals based on each hospital's share of Medicare IME payments over a three-year base period. Funding for this new payment would come from general revenues, thus broadening the source of payment for teaching costs.

The President's proposal would lower the IME adjustment to 7.2 percent in 1996, after which it would decline in stages to 6.0 percent in fiscal year 2001. In addition, residents who were beyond their initial residency period would be counted as half an FTE for determining IME payments, as they are for GME payments. Under the proposal, residents who work in non-hospital settings also would be included in the hospital's IME resident count.

The IME adjustment continues to be higher than what the Commission has recommended in past years. Both the Congress and the President would reduce this adjustment from its current level. The President's proposal would lower it more slowly, but would also apply Medicare GME resident count and weighting rules to the IME resident counts. Treating the IME resident counts like those for GME would strengthen incentives to train residents in primary care specialties. The Commission is intrigued by such a policy, but has not examined its potential financial impact on hospitals. Such a policy could also affect the technically appropriate level for the IME adjustment. ProPAC plans to study this issue further. Finally, it is important that the impact of reducing IME payments, together with any reduced funding for disproportionate share payments, be closely monitored to make sure that Medicare beneficiaries' access to quality care is maintained.

Other Support for Teaching-Related Costs

The Congress's proposal would establish a Teaching Hospital and Graduate Medical Education Trust Fund to help support the cost of training residents. A total of \$13.5 billion would be appropriated to the fund from general revenues between fiscal years 1997 and 2002, establishing a broader source of public support for residency training. A specified percentage of the general revenue funds would be allocated to a MedicarePlus Incentive Account. The remaining money would be allocated to the General Indirect-Cost Medical Education Account and General Direct-Cost Medical Education Account, based on the share of Medicare spending in fiscal year 1994 for IME and GME, respectively.⁸

The MedicarePlus Incentive Account would distribute funds to teaching hospitals based on their share of MedicarePlus admissions among all teaching hospitals. Thus, the size of a hospital's teaching program and the complexity of its patient population would not affect these payments. Hospitals with many MedicarePlus patients would be greatly rewarded for having only a few residents. Hospitals with a large teaching commitment, however, would receive the same per case payment as these other hospitals. Moreover, because the size of the fund is fixed, the actual per case payment would depend on the total number of MedicarePlus admissions to teaching hospitals. Consequently, if few beneficiaries entered the MedicarePlus program or if few of these enrollees used teaching hospitals, the per case payment would likely be much higher than the associated costs. The reverse would be true if there were significant MedicarePlus participation, particularly in teaching hospitals.

The General Indirect-Cost Medical Education Account would distribute funds to teaching hospitals based on the share of total Medicare IME payments each hospital received over a three-year base period (1992 to 1994). Payments would not be affected by changes in the number of residents trained or the number and mix of patients treated. The General Direct-Cost Medical Education Account would distribute funds in a similar manner, based on a hospital's share of Medicare direct graduate medical education payments over the 1992 to 1994 period. The general direct-cost payment would thus depend on the hospital's per resident payment amount, resident count, and Medicare share of inpatient days in the

base period. It would not be adjusted, however, for changes in these factors between the base year and the time payments are made.

Distributing these two new accounts based on past Medicare spending for teaching may not be an effective way to provide broader general support for teaching-related expenses. This is because hospitals with high levels of Medicare teaching payments would also receive a large portion of these new general revenue payments. Conversely, hospitals with a low share of Medicare teaching payments, such as children's hospitals and some urban public hospitals, would receive little financial support from these general funds, even though they may have the same overall number of residents. The Commission is exploring a number of alternatives for distributing these funds. ProPAC will forward to the Congress later this year its views on how best to distribute general revenue payments so that they provide broader financial support for teaching-related activities in all settings.

The President's proposal would provide funds for teaching-related costs for Medicare beneficiaries in capitation programs. It would remove teaching-related payments from the Medicare capitation rates and return 75 percent of these funds to health maintenance organizations, hospitals, and other providers that operate teaching programs for the teaching costs of care provided to beneficiaries enrolled in capitation plans. This would result in lower capitation rates, particularly in some areas with a large number of teaching hospitals. Medicare participating health plans would need to adjust to these rates by reducing extra benefits, renegotiating provider contracts, accepting lower profits, or in other ways.

DISPROPORTIONATE SHARE HOSPITAL PAYMENTS

The disproportionate share (DSH) adjustment originally was intended to offset the cost-increasing effect of treating low-income patients. In recent years, its purpose has been viewed more broadly as preserving access to care for low-income populations by financially assisting the hospitals they use.

The amount of DSH payment each hospital receives is determined by a complex formula and

each hospital's disproportionate share patient percentage. This percentage is derived as the sum of two ratios: Medicaid patient days as a share of total patient days and patient days for Medicare patients eligible to receive Supplemental Security Income cash payments as a percentage of total Medicare patient days. Most DSH payments go to urban hospitals.

The congressional proposal would not change the method of distributing DSH payments, but would substantially reduce funding for the adjustment. The cutback would be implemented in annual increments, beginning at 5 percent in 1996 and reaching 30 percent in 2000. The President's proposal includes a smaller funding reduction—10 percent—beginning in 1999.

These reductions would be implemented at a time when hospitals relying heavily on the DSH adjustment are facing competitive pressures that make it increasingly difficult to generate funds to cover their uncompensated care costs. Moreover, the number of people unable to pay for hospital care is likely to increase in the coming years. Even with insurance premiums rising more slowly than in the past, additional employers may drop health insurance coverage for their employees. Further, under the comprehensive Medicaid reforms proposed by the Congress, some states might elect to scale back Medicaid eligibility and service coverage. Finally, many local governments operating hospitals are facing their own financial pressures, which may make it difficult for them to maintain the level of operating subsidies they formerly provided.

Reductions in funding for the DSH adjustment highlight the importance of ensuring that the hospitals with the greatest need receive payments. However, optimizing the allocation of DSH funds is complicated by the use of a Medicaid variable in the distribution formula.

Medicaid utilization has never been a good measure of service to the poor, because the proportion of the low-income population covered by the program varies substantially from state to state, and the hospitals that provide the most care to uninsured low-income patients do not necessarily treat the most Medicaid patients. The misallocation may have been exacerbated in recent years by reforms a number of states have undertaken. Of particular

concern is the substantial expansion in eligibility for Medicaid in Oregon and Tennessee, with little or no indication of change in these states' low-income populations.⁹ Moreover, the accuracy of a Medicaid patient day count in representing the amount of care provided to the poor may deteriorate even further under the expanded state role envisioned by the Congress. With much greater control over the design of their programs, some states may broaden eligibility and service coverage while others scale them back—all with virtually no relationship to the amount of care needed by the poor.

Because of these problems, it will be essential to improve the accuracy of the data used to distribute DSH payments. This should be done in the context of a comprehensive review of the objectives of the DSH adjustment and the methods available to best accomplish them. One important methodological issue is what populations to include, as the measure now used for distributing payments does not reflect a significant portion of hospitals' low-income patient loads. It will also be important to define the scope of patient care to be covered, such as whether DSH payments should apply to outpatient care or to hospital services provided in Medicare capitation programs.

The most appropriate measure of low-income patient care must then be identified. The primary choice here is between a measure of the amount of care provided to low-income patients and the losses incurred in treating the poor. Data collection methods would also need to be assessed, since most of the likely options for distributing payments would require new data. This presents a trade-off between the level of hospital reporting burden and the ability to allocate DSH monies among providers in the desired manner. In addition, it may be necessary to deal with the difficult issue of measuring charity care.

Revamping the DSH adjustment is potentially a complex process. However, inasmuch as the facilities now relying on DSH payments face growing pressure from private payers, Medicaid, and Medicare, the distribution of available funds will be crucial in protecting access to care for vulnerable populations.

DISCHARGES FROM PPS HOSPITALS TO OTHER FACILITIES

A per case payment system like PPS provides hospitals with a strong incentive to reduce length of

stay. Hospitals can shorten stays by changing their practices to provide care more efficiently. They also can reduce the amount of care furnished in the inpatient setting by moving patients out of the hospital to other locations. When PPS began, there was evidence of this site-of-care substitution. Hospitals began conducting more preoperative tests in the outpatient setting, for example, instead of admitting the patient to the hospital the day before surgery.

The recent growth in the use of post-acute services, together with declines in PPS inpatient length of stay, raises the issue of whether site-of-care substitution is now occurring at the end of the hospital stay. (See Chapter 4 for a more complete discussion of this trend.) Many of the services delivered in post-acute settings may formerly have been provided in PPS hospitals. If payments are not adjusted to reflect any shift in site-of-care delivery, Medicare may be paying twice for the same service: once in the hospital, where the DRG payment rate reflects the cost of services no longer provided, and again in the post-acute care setting, where the service is now furnished. Although the DRG weights eventually reflect the relative resources required to treat the average case in a DRG, aggregate PPS payments do not reflect the shifting of these services from the hospital unless the PPS update accounts for this change in the hospital's product.

The President proposes to apply Medicare's transfer payment policy to patients who are discharged to PPS-excluded hospitals and units and to skilled nursing facilities. Hospitals that discharge patients to one of these facilities after a stay of at least a day less than the average for the DRG would receive a graduated per diem payment instead of the full DRG amount. Thus, PPS payments would be reduced when services were transferred from the hospital to post-acute sites. In addition, the proposal would stabilize the weights for DRGs with significant site-of-care shifts. This would allow the DRG weights to better reflect the cost of care provided to patients who were not discharged to another setting.

The Administration's proposal, however, would reduce hospitals' incentive to discharge patients to post-acute settings. This could result in longer hospital stays, even though the cost of providing care might be lower and the level of care might be more

appropriate in post-acute sites. This proposal could substantially weaken PPS incentives to shorten inpatient lengths of stay, leading to a less appropriate continuum of care for Medicare beneficiaries. Therefore, the likely effects of such a policy on hospital behavior need to be better understood before implementation proceeds.

CONCLUSIONS AND RECOMMENDATIONS

The Commission has developed recommendations in each of the policy areas addressed above. These include updates for the operating and capital components of PPS and PPS-excluded hospital payments, teaching and disproportionate share payments, and payment for discharges from PPS hospitals to post-acute facilities. Despite the emphasis on capitation programs in both the congressional and presidential proposals, these payment policies will continue to govern the majority of Medicare payments for inpatient hospital services.

Recommendation 10: Updating PPS Operating Rates

ProPAC's update framework would support an update between 0.7 percentage points and 2.0 percentage points less than the increase in the hospital market basket index. The methodology employed by the Commission in previous years would lead to a recommendation of about market basket minus 1.5 percentage points, roughly corresponding to the midpoint of that range. In light of the significant changes occurring in health care delivery, the Commission believes that PPS payment rate increases could be held to market basket minus 2.0 percentage points for the next year or two. However, it is concerned about the potential effects of continuing updates at that level on hospitals' ability to provide quality care to Medicare beneficiaries and other populations.

ProPAC's update framework accounts for the effects of inflation on hospital costs, adjusting for case-mix change, scientific and technological advances, and productivity improvements. The congressional proposal of market basket minus 2.0 percentage points falls within the range that results

from applying the Commission's framework. The Congress, however, would set the update at this level through 2002.

In the short run, hospitals should be able to continue their recent productivity growth, and thus should not be adversely affected by an update that is 2.0 percentage points below the hospital market basket increase. Payers are applying pressure on providers—particularly hospitals—to restructure the way they operate and constrain the growth in their costs. Hospital occupancy rates remain relatively low in aggregate, indicating substantial system overcapacity and ongoing opportunities for hospital productivity improvements. Hospitals can continue to better the efficiency of staffing and capital purchasing as well. In view of the changes now occurring in the health care market, hospitals should still be able to provide quality care for the immediate future, despite this constrained rate of growth.

If updates are held to this level through 2002, though, hospitals may not be able to continue providing access to quality care. It is unclear, for instance, how long they will be able to support the productivity improvements needed to keep cost per case increases down to the level required by the proposed updates. Furthermore, some of the changes other payers are making, such as controlling the use of inpatient hospital services, will reduce hospital volume. This could raise per case costs for hospitalized patients. Moreover, a continuation of cost constraint at this level could require hospitals to forego technological advances that may significantly improve quality and patient outcomes. Finally, there is the basic uncertainty about the future. The Commission is concerned that once the updates become law, it would be extremely difficult to increase them to respond to deteriorating quality and hospital financial condition, should that occur.

Recommendation 11: Setting Capital Payment Rates

Prospective per discharge payment rates for inpatient capital costs should be set by developing an appropriate base payment rate and applying an annual update. The capital update should reflect the prices of capital assets, capital financing costs, and

other factors related to the capital costs hospitals incur in efficiently providing inpatient care to Medicare beneficiaries.

The capital payment rates currently in effect are based on estimated fiscal year 1992 hospital capital costs per discharge, updated by historical capital cost increases through 1995 and a prospective update framework for 1996. ProPAC has long opposed the use of historical cost increases, proposing instead that a prospective framework similar to that applied to PPS operating payments be used.

In the first four years of capital prospective payment, the effective capital payment rate has differed from the base payment rate due to a congressional requirement that total anticipated capital payments equal 90 percent of total anticipated capital costs. When this budget neutrality requirement expired at the end of fiscal year 1995, actual capital payment rates for 1996 went up more than 20 percent.

The Congress has proposed extending the budget neutrality requirement through fiscal year 2002 and setting payment rates so that total capital payments equal 85 percent of total anticipated capital costs. While this would eliminate the large increase in capital payments in 1996, it would continue the relationship between capital payments and costs in each year. The Commission believes that Medicare should move to a fully prospective capital payment system, severing the link between payments and costs.

Recommendation 12: Updating Payments to PPS-Excluded Hospitals and Distinct-Part Units

ProPAC's update framework would support an average update to the TEFRA target amounts equal to the projected increase in the market basket index minus 0.6 percentage points for fiscal year 1997. This average is within the range of facility-specific updates in the Congress's proposal, which is between the market basket increase and 2.5 percentage points below market basket. Major changes to the TEFRA target amounts should not be made at this time. Rather, a prospective payment system for PPS-excluded hospitals and

distinct-part units should be implemented as soon as practicable.

ProPAC's update framework for payments to PPS-excluded hospitals and distinct-part units reflects the market basket increase for these facilities, corrected for previous forecast error. Unlike the Commission's approach for updating PPS payments, this framework does not include adjustments for productivity or case-mix change. It does reflect an allowance for scientific and technological advances, although this was zero for fiscal year 1997. Given the structural changes occurring in the hospital industry, the Commission believes PPS-excluded hospitals and distinct-part units should be able to successfully constrain their cost increases and still provide access to quality care within the provisions of the congressional proposal, at least for the next year or two.

Financial performance varies widely among PPS-excluded hospitals and distinct-part units, particularly between new facilities and those that have been operating for many years, according to ProPAC analyses. Much of this variation is related to the design of the TEFRA payment system rather than to hospital behavior. TEFRA is not suited—and was not intended—for long-term application. Rebasement of the target amounts, however, would not solve the system's inherent problems. Assigning a more recent base year would increase payments to older facilities, which would improve payment equity somewhat. Yet older facilities would still be at a competitive disadvantage because recent costs would reflect past spending patterns that were constrained by the annual updates. A prospective payment system would recognize appropriate cost differences and reward efficient facilities, particularly older ones that have responded to TEFRA's incentives.

Because there is no acceptable measure of case mix, implementation of a prospective payment system in the near term is not feasible. The development of a patient classification system for rehabilitation hospitals and distinct-part units is progressing, but few advances have been made for other PPS-excluded providers. The Secretary should accelerate efforts to develop effective patient classification systems that can form the basis of a prospective payment system for these providers. (See Recommendations 20 and 21.)

In the meantime, the formulas for updating the TEFRA target amounts under current law and in the congressional proposal appropriately recognize that all facilities do not realize identical cost increases and allow for differential updates across providers according to individual experience. The Commission will continue to examine the TEFRA payment system and its effect on providers.

Recommendation 13: Broadening Financial Support to Teaching Hospitals

Explicit financial support for graduate medical education activities should not be limited to the Medicare program. Mechanisms to broaden financial support for teaching-related activities in hospitals and other locations should be developed.

Medicare is the only payer that explicitly pays hospitals for the direct and indirect costs of teaching activities. Although other payers have implicitly provided funding for these activities by paying higher prices for patient care services, there is no direct connection between the amount of payment and the size or structure of the teaching program. Moreover, because the implicit support for teaching activities is not separable from the price of patient care at teaching hospitals, these facilities are at a disadvantage relative to non-teaching hospitals because of higher prices related to their teaching mission. As hospital markets become more competitive with the growth of managed care and other structural changes, it will be increasingly difficult for teaching hospitals to compete for patients from price-sensitive insurers.

To allow teaching hospitals to compete fairly with other institutions, the Commission supports the concept of an all-payer fund to help underwrite teaching activities at hospitals and in other settings. The Teaching Hospital and Graduate Medical Education Trust Fund proposed by the Congress would provide broader support for these activities by using both general revenues and Medicare payments. As centers for training future physicians, leaders in research, and providers to underserved populations, teaching hospitals are an integral part of this nation's health care delivery system. It is important that they remain viable in this role.

Recommendation 14: Medicare Payments for Graduate Medical Education Costs

ProPAC supports changes in Medicare teaching payments that would encourage an appropriate distribution of residents across specialties and discourage inappropriate growth in the total number of residents.

Medicare payments should foster an appropriate specialty balance and supply of future practicing physicians. Both the President's and the Congress's proposals for Medicare direct GME payments would move in this direction. The President's proposal would provide greater incentives for training primary care residents than for those in other specialties, which is desirable. The Congress would discourage the growth in the number of residents while relying more on market forces to determine the number and distribution of physicians. Medicare payments should reflect the desired change in direction, rather than impeding these changes.

Recommendation 15: Medicare Indirect Medical Education Payments

The Medicare indirect medical education adjustment should be reduced from its current 7.7 percent level to 7.0 percent.

Ultimately, the Medicare IME adjustment should be reduced from its current 7.7 percent level to one that corresponds more closely to the actual relationship between teaching intensity and costs. The final level of the adjustment, however, should depend on what other changes are made in the Medicare program. The Commission therefore recommends an initial reduction of the IME adjustment to 7.0 percent. As the adjustment is reduced, it will be important to monitor teaching hospitals' financial condition and the effect on access to their services.

ProPAC also supports the concept of basing IME payments on resident counts and weighting factors consistent with those used in GME payment. Additional analysis is needed to examine the effect of this policy on individual teaching hospitals, however. The Commission recommends proceeding cautiously with such a change. It is also important to point out that the technically appropriate level of

the teaching adjustment would change with such a policy. ProPAC plans to examine in more detail the impact of this policy on hospitals and on the empirical relationship between teaching intensity and hospital costs.

Recommendation 16: Distributing Additional Teaching-Related Payments

Funds that provide broader financial support for graduate medical education should be distributed in a way that corresponds to the additional costs incurred by teaching facilities. Providers that treat enrollees in capitation plans should receive teaching-related payments for those patients as well as for the other patients they serve.

ProPAC is concerned about how general revenues would be disbursed through the General Indirect-Cost Medical Education Account and the General Direct-Cost Medical Education Account. The distribution of payments from these accounts would be based on previous Medicare payment levels, even though the funds would come from general revenues. Hospitals with a high share of Medicare teaching payments would receive a proportionately higher share of these new payments compared to hospitals with the same amount of teaching activity but a low share of Medicare patients. Payments based on prior Medicare utilization may not achieve their broader purpose. Over the coming year, ProPAC will examine how best to provide general support for teaching-related activities.

Additionally, funding mechanisms are needed so that teaching hospitals can compete effectively in the managed care market. Such mechanisms should give participants in Medicare's capitation program an incentive to use teaching hospitals when needed while paying providers appropriately for serving capitation patients. How funds would be disbursed to hospitals under the Congress's proposed MedicarePlus Incentive Account concerns the Commission. First, these payments would not account for differences in the intensity or size of hospital residency programs. Second, because the total payments available through this account would be fixed, they would not reflect Medicare beneficiaries' use of the proposed MedicarePlus program. Payments from a fund like this one should reflect the amount of teaching activity in a hospital and

other teaching settings. Further, total payments made through such a mechanism should depend on Medicare beneficiaries' participation in capitation programs.

Recommendation 17: Disproportionate Share Hospital Payments

The Commission is concerned about the potential impact of reductions in DSH payments. Hospitals that treat a large number of the uninsured could be particularly vulnerable because of recent changes in the health care environment. Large reductions in DSH payments would threaten the continued ability of many of these hospitals to serve populations who depend on them for access to care.

With increasing numbers of people lacking health insurance and contraction in many state and local programs designed to fund care for them, hospitals' uncompensated care burdens will likely be higher than ever in the coming years. Many of the hospitals that treat large numbers of uninsured patients are teaching institutions, which are facing stepped-up price competition in the private market along with substantial cutbacks in their IME payments. But some non-teaching hospitals also have significant low-income patient shares, and even among those involved in medical education, the amount of service to the poor frequently does not correspond to the level of teaching intensity. The financial integrity of many hospitals that play a critical role in ensuring access to care for low-income patients may be affected by changes occurring in the public and private financing of medical care. The role they serve will, if anything, become more important in the near future and should be protected.

Recommendation 18: Method for Distributing Disproportionate Share Payments

The structure of the DSH adjustment should be reviewed to make certain that available funds are distributed equitably among the hospitals most in need of assistance. This may require collecting new data to develop a better measure of the services hospitals provide to indigent patients.

The distribution of DSH payments is determined partly by each hospital's Medicaid patient days as a

percentage of total days. Medicaid utilization has never been an optimal measure of service to low-income patients, and its accuracy is deteriorating even further with changes taking place in the structure of the Medicaid programs in several states. Moreover, this problem would be exacerbated by the Medicaid reforms the Congress has proposed.

An alternative method of distributing DSH payments should be considered, but in the context of a comprehensive review. This review should begin by assessing the objectives of the DSH adjustment. It should also extend to defining the low-income population to be covered and identifying the scope of patient care to be included (for example, outpatient care or services furnished under the Medicare capitation program). Alternative measures of low-income patient care could then be considered, including the data collection each would require.

Recommendation 19: Discharges from PPS Hospitals to Other Facilities

Medicare payments should be modified to account for the shift in services from acute to post-acute settings. Broadening the definition of transfer cases, however, is not an appropriate approach.

PPS provides hospitals with a strong financial incentive to reduce length of stay by moving care to other settings, since in most cases payments are the same regardless of whether the full course of treatment is provided in the hospital. Although the DRG weights eventually reflect this shift in services, aggregate Medicare payments do not. Constrained updates due to expected productivity improvements may appropriately adjust aggregate payments, but they will not account for cost differences between patients who use post-acute services and those who do not.

The President proposes to treat as transfers those cases who are discharged to skilled nursing facilities and PPS-excluded hospitals and units. The Commission, however, thinks this policy would discourage the use of post-acute providers. Moreover, it could result in longer inpatient stays, which may not be desirable or cost effective in the long run. The expanded transfer policy, therefore, should not be implemented without additional analysis of its impact. Other policies that would better integrate the payment system across settings need to be studied. One would be to bundle acute and post-acute services for certain DRGs into a single payment rate. Another would be to develop DRGs that reflect the use of post-acute services. The Commission will continue to examine methods to better integrate the fee-for-service payment system and will work with the Secretary on this endeavor.

Notes to Chapter 3

1. The Congress's Medicare provisions are in H.R. 2491, the "Balanced Budget Act of 1995." The Medicare provisions of the President's plan are in Title 11 of draft legislation, called the "Balanced Budget Act of 1995 for Economic Growth and Fairness." Released on December 7, 1995, this proposal has not been introduced in the Congress.
2. The PPS margin is the difference between the PPS operating payments a hospital receives and the operating costs of treating its Medicare patients, taken as a percentage of the payments.
3. ProPAC views cost shifting as a dynamic process whereby changes in payments relative to costs for some payers are offset by changes for other payers. During the late 1980s, increasing losses from Medicare, Medicaid, and uncompensated care were offset by increasing gains from private payers. For more information on this issue, see Prospective Payment Assessment Commission, *The Relationship of Hospital Costs and Payments by Source of Revenue, 1980-1991*, ProPAC Intramural Report I-95-01, October 1995.
4. Prospective Payment Assessment Commission, *Hospital Costs and Payments by Revenue Source: The Impact of Medicaid Payment Increases in 1992*, ProPAC Intramural Report I-95-05, October 1995.
5. The rehabilitation industry and the research community have developed a patient classification system for rehabilitation hospitals and distinct-part units (referred to as functional-related groups) that is based on patient functional status. HCFA is evaluating how well this technique works in grouping patients.
6. The Omnibus Budget Reconciliation Act of 1990 required the Secretary of Health and Human Services to propose either a prospective payment system for PPS-excluded providers or modifications to the current TEFRA system. The Act also required ProPAC to analyze and comment on the proposal. Absent the Secretary's proposal, the Commission submitted an interim report to the Congress that examined the financial condition of PPS-excluded providers and explored broad alternative payment methods. Prospective Payment Assessment Commission, *Interim Report on Payment Reform for PPS-Excluded Facilities*, Congressional Report C-92-05, October 1992.
7. Data on the amount of payment adjustments received through the exceptions process are not systematically collected or automated. In addition, there is a considerable lag between the time an exception is granted and when it appears as a higher target amount on the cost report.
8. The trust fund would also receive revenue from Medicare to support the Medicare Indirect-Cost Medical Education Account and the Medicare Direct-Cost Medical Education Account. Money from these two accounts would be used to finance indirect medical education adjustment payments and direct graduate medical education payments to certain hospitals that operate graduate training programs for interns and residents.
9. HCFA has attempted to minimize the bias resulting from the major reform in Tennessee and plans to do so for Oregon. Under HCFA's directive, Tennessee's Medicaid agency furnishes each hospital with a list of its patients who would have been eligible for Medicaid under the prior criteria. The hospitals then use this information to provide the Medicare fiscal intermediary with a restricted count of Medicaid days. This is an administratively difficult procedure, and does not appear to be a realistic approach for ensuring consistent Medicaid utilization data in the future.

Chapter 4

Post-Acute and Ambulatory Care Providers

Post-Acute and Ambulatory Care Providers

As the share of Medicare expenditures devoted to hospital inpatient services declines, the share devoted to post-acute and ambulatory care continues to rise. This shift in spending primarily reflects major changes in the volume and mix of services used. Revisions in Medicare's coverage policies explain some of the increased use of post-acute services, but Medicare payment policies also encourage the growth of both post-acute and ambulatory care. Medicare's prospective payment system (PPS) provides incentives for hospitals to reduce costs by shifting services from inpatient to other settings. At the same time, the way that Medicare pays for post-acute and ambulatory facilities offers few incentives for providers to reduce their costs and control the volume of services they furnish.

Medicare has instituted many changes to its post-acute and ambulatory payment policies to contain its cost per service. An effective volume control measure has remained elusive, however. The overlap of services delivered across settings and the lack of a uniform definition of service units contribute to the difficulty in addressing this problem. Both the Congress and the President propose implementing prospective payment systems for services provided by skilled nursing facilities (SNFs) and home health agencies, the most significant sources of post-acute expenditures.¹ The prospective payment amount would apply to all the services furnished by the facility for an episode of care.

This chapter presents background information to support the Prospective Payment Assessment Commission's (ProPAC's) recommendations for payments to post-acute and ambulatory care providers. The recommendations reflect the Commission's concerns about expenditure growth within and across treatment settings. The first section focuses on rehabilitation facilities and long-term care hospitals, skilled

nursing facilities, and home health agencies. It documents spending growth, payment policies, and proposed changes for each type of provider, concluding with ProPAC's recommendations. The second section contains comparable information for dialysis facilities and hospital outpatient departments.

POST-ACUTE CARE PROVIDERS

Payments to post-acute care providers are the fastest growing component of Medicare expenditures. Rehabilitation facilities, long-term care hospitals, skilled nursing facilities, and home health agencies accounted for more than 22 percent of Medicare Part A spending (including both program and beneficiary contributions) in 1993, up from about 7 percent in 1986 (see Table 4-1).

Post-acute care expenditures have been driven by a rapid growth in service utilization. Rehabilitation facility admissions per 1,000 beneficiaries, for example, climbed 148 percent between 1986 and 1993 (see Table 4-2). The increase in beneficiaries receiving care in a skilled nursing facility was similar over this period. Use rates for long-term care hospitals and home health agencies experienced marked growth as well.

Higher utilization is partly attributable to practice pattern changes resulting from Medicare coverage policies: Medicare relaxed restrictions on the coverage of home health and SNF services in the late 1980s, expanding the number of beneficiaries eligible to receive post-acute care. But payment policies for both acute care hospitals and post-acute care providers also contributed to greater use.

Medicare's PPS rewards acute care hospitals for reducing costs per admission. The most direct way for hospitals to lower costs is to shorten stays. In 1984, the Medicare average length of stay in a PPS hospital was 8.8 days. It fell to 8.1 days in 1991

Table 4-1. Distribution of Total Medicare and Beneficiary Payments for Selected Part A Services, 1986-1993

Year	Share of Part A Payments (In Percent)					Total Part A Payments (In Millions)
	PPS Hospital	Rehabilitation	Long-Term Care	Skilled Nursing	Home Health	
1986	91.2%	1.5%	0.2%	1.5%	3.7%	\$ 53.3
1987	90.6	1.8	0.2	1.5	3.5	54.3
1988	89.3	2.0	0.3	2.2	3.6	59.0
1989	85.6	2.2	0.3	5.5	4.0	65.1
1990	84.1	2.6	0.3	4.8	5.4	72.4
1991	81.9	3.0	0.3	4.8	7.0	81.2
1992	78.1	3.4	0.3	6.3	8.7	91.3
1993	74.3	3.6	0.5	7.9	10.4	102.5

Note: The percentages do not add to 100 percent because shares for hospices, cancer hospitals, children's hospitals, and psychiatric facilities are not shown. All numbers include both program and beneficiary payments.

SOURCE: ProPAC analysis using Medicare Cost Reports and other data from the Health Care Financing Administration.

and by another 13.1 percent to 7.1 days by 1994. Often the shortened stays were accomplished by providing some services that once were part of the hospitalization in a post-acute setting. In fact, ProPAC analysis found that for the 12 diagnosis-related groups (DRGs) most likely to result in post-acute service use, acute hospital length of stay reductions were greater than the average for all DRGs. From 1991 to 1994, length of stay for these DRGs fell more than 16 percent and as much as 28 percent, significantly more than the overall drop.

In 1995, about 58 percent of PPS hospitals had a skilled nursing facility, SNF swing beds, or a

rehabilitation unit. ProPAC analysis showed that for the 12 DRGs with high post-acute use, hospitals with post-acute units had shorter lengths of stay than those without units. The difference may be that post-acute services were more readily available in hospitals that had such units. In addition to being able to lower costs subject to the PPS rate, hospitals that own post-acute units gain other financial advantages. They can raise the occupancy of the facility overall, thus providing a larger patient base over which to spread fixed costs. Other resources, such as expensive equipment or certain specialized personnel, also can be used more efficiently over a larger patient base and thus can lower per unit costs.

Table 4-2. Medicare Utilization for Selected Part A Services, 1986-1993

Year	Admissions Per 1,000 Beneficiaries ^a			Persons Served Per 1,000 Beneficiaries ^b	
	PPS Hospital	Rehabilitation	Long-Term Care	Skilled Nursing	Home Health
1986	316.5	2.9	0.4	9.6	49.8
1987	304.4	3.3	0.4	9.1	47.9
1988	298.7	3.7	0.5	11.7	48.1
1989	288.0	4.0	0.5	19.0	50.3
1990	285.6	5.0	0.5	18.7	56.8
1991	284.7	5.9	0.5	19.3	63.9
1992	285.5	6.6	0.6	22.1	71.0
1993	285.3	7.2	0.7	24.0	80.1
Percent change 1986-1993	-9.9%	148.3%	75.0%	150.0%	60.8%

^a Admissions per 1,000 beneficiaries counts all admissions, not the number of beneficiaries who were hospitalized at any time during the year.

^b Persons served per 1,000 beneficiaries counts the number of beneficiaries who were provided the service in a given year, not the number of admissions.

SOURCE: ProPAC analysis of Medicare Cost Reports and data from the Health Care Financing Administration.

Medicare's payment policies for post-acute providers also have contributed to the expansion of post-acute service use and expenditures. Rehabilitation facilities and long-term care hospitals receive cost-based payments at least for their first two years of operation, after which payments are limited by a facility-specific cap. This payment method encourages the development of new facilities and rewards those that have high costs. Skilled nursing facilities also are paid their incurred costs up to a limit for routine services, such as room, board, and nursing care. However, because of varying definitions of the costs subject to these limits and open-ended cost reimbursement for ancillary services, payments per beneficiary have increased substantially. Further, despite per visit home health payment limits, the number and scope of services provided are not restrained and as a result have grown.

Medicare's post-acute facility payment methods have been modified over the years to control expenditures. Several characteristics of post-acute providers, however, make it difficult to slow spending. One is the overlap of services delivered across sites. All of these facilities provide therapy—speech, physical, and occupational—as well as more medically related nursing services. At least a portion of the patient population in any of these settings could be treated in another site. Yet because the payment methods and rates vary across providers, the Medicare program pays different amounts for the same or similar services, depending on where they are delivered.

Service payment units are not measured consistently across settings, which also contributes to the difficulty in controlling costs. Rehabilitation hospitals, for example, receive a per stay payment. By contrast, skilled nursing facilities are subject to per diem cost limits for routine services, and ancillary services are paid separately. As a result of the various payment definitions and methods, the total costs for an episode of care cannot be compared across sites. Thus, it is difficult to ensure that Medicare's policies encourage the most cost-effective methods of care. Even the payment modifications proposed by the Congress and the President would not facilitate comparisons of service volume, patient mix, or case severity across post-acute providers.

An additional complication is the changing nature of service delivery and organization.

Increasingly, many of these providers are offering a level of care labeled “subacute.” Less intensive than the care traditionally offered in a hospital, subacute care may describe the set of services formerly provided at the end of a hospital stay. Some beneficiaries who bypassed an acute care hospital to receive rehabilitation services or to be admitted to a long-term care hospital may be receiving subacute care. Because Medicare's payment methods vary across provider type, they do not consistently reflect the type or level of care a patient receives. Consequently, Medicare payments frequently do not reflect new patterns of service delivery.

Rehabilitation Facilities and Long-Term Care Hospitals

Rehabilitation facilities and long-term care hospitals are paid in accordance with the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). Under TEFRA, payments for inpatient operating costs are based on each facility's current Medicare-allowable costs or a facility-specific limit. The limit (or target amount) equals the facility's allowable costs per discharge in a base year, trended to the current year by an annual update factor. Capital payments are based on reasonable costs. (See Chapter 3 for a complete description of the TEFRA payment method.)

When TEFRA was enacted in 1982, it applied to all hospitals. The Congress intended it to be a temporary measure to slow hospital expenditure growth until a fully prospective payment system could be implemented. When PPS began on October 1, 1983, however, certain types of hospitals and distinct-part units were excluded because DRGs and payments based on national average costs were not appropriate for them. The Congress expected that a separate prospective payment system for these facilities would be implemented within a few years.

PPS-excluded facilities have continued under the TEFRA payment system for longer than expected, however. This is because adequate patient classification systems, which are needed for a prospective payment system, have not been developed. Consequently, several flaws inherent in TEFRA that would have had little significance in the short run have led to growth in aggregate Medicare utilization and expenditures over time, as well as substantial inequities across providers.

Of primary concern is the use of facility-specific costs to set base payment limits. Because the expense of opening a new facility is higher today than in the past, facilities with more recent base years automatically have higher limits and receive higher payments. The incentive to open a facility is strengthened by the fact that newly certified PPS-excluded hospitals or units are exempt from the TEFRA limits for their first two 12-month cost reporting periods. During this time, Medicare pays on the basis of reasonable costs; the second cost reporting period is designated as the base year.² Consequently, new providers have no incentive to avoid high start-up costs because these result in higher base year costs and higher future cost limits.

Moreover, acute care hospitals that treat a large number of long-stay cases or patients who require rehabilitative care have a strong incentive to establish rehabilitation distinct-part units or separate long-term care hospitals within hospitals. By doing this, an acute care hospital can lower its costs subject to PPS and reallocate some expenses to its specialty hospital or to a unit that receives cost-based reimbursement. To the extent that the TEFRA payment for long-stay or rehabilitation cases is greater than the regular DRG payment plus any outlier payment under PPS, the financial benefit could be substantial.

Growth in Facilities, Utilization, and Expenditures—The number of Medicare-certified rehabilitation and long-term care facilities has grown rapidly over the last decade (see Table 4-3). Between 1986 and 1994, rehabilitation hospitals and distinct-part units grew by 160 percent and 75 percent, respectively. After dipping in the late 1980s, the number of long-term care hospitals increased from 90 in 1990 to 146 in 1994. Similarly, Medicare

discharges from rehabilitation hospitals and units combined rose by 39 percent from 1990 to 1993, and long-term care hospital discharges grew by 48 percent over the same period (see Table 4-4).

The proliferation of providers and the growth in discharges have led to a marked increase in aggregate Medicare spending for rehabilitation and long-term care facility services (see Table 4-5). Total payments to rehabilitation hospitals and units combined rose from \$1.9 billion in 1990 to \$3.7 billion in 1993—a 95 percent increase. Although Medicare payments to long-term care hospitals are comparatively small, they grew by 150 percent over the same period.

The TEFRA payment system was designed to moderate the growth in Medicare hospital payments by giving facilities an incentive to constrain cost increases. Recent ProPAC analyses indicate that lengths of stay in rehabilitation and long-term care facilities have declined and annual per case cost increases have slowed for certain groups of facilities. Yet aggregate Medicare inpatient operating payments per discharge for these providers have risen, on average, faster than the market basket. In fact, aggregate operating payments to long-term care hospitals grew by about 15 percent per year from 1990 to 1993. This is primarily due to the large number of new providers that entered the TEFRA payment system with higher costs, resulting in higher aggregate payments.

Proposed Payment Changes—The Congress's and the President's proposals contain provisions to curb TEFRA payment increases through lower updates to the target amount, capital payment reductions, limits on exceptions adjustments, and restrictions on additional payments for facilities

Table 4-3. Medicare-Certified Rehabilitation and Long-Term Care Facilities, Selected Years

Facility Type	1986	1988	1990	1992	1994	Percent Change 1986-1994
Rehabilitation	545	697	813	923	1,019	87%
Hospitals	75	106	135	164	195	160
Distinct-part units	470	591	678	759	824	75
Long-term care	94	82	90	102	146	55

SOURCE: Health Care Financing Administration, Office of Survey and Certification.

Table 4-4. Medicare Discharges from Rehabilitation and Long-Term Care Facilities, 1990-1993

Facility Type	1990	1991	1992	1993	Percent Change 1990-1993
Rehabilitation	169,491	198,423	223,948	235,212	39%
Hospitals	55,814	65,248	73,479	68,297	22
Distinct-part units	113,677	133,175	150,469	166,915	47
Long-term care	15,262	16,474	18,334	22,514	48

Note: Due to missing and inaccurate data, these figures do not represent total Medicare discharges.

SOURCE: ProPAC analysis of Medicare Cost Report data from the Health Care Financing Administration.

with operating costs above their target amounts. (See Chapter 3 for more information regarding these proposals.) Neither proposal, however, addresses the need to control utilization, although the President proposes to place a moratorium on certifying new long-term care hospitals.

Skilled Nursing Facility Services

The Medicare Part A SNF benefit provides up to 100 days of post-acute care per spell of illness. To be eligible, Medicare beneficiaries must have completed a minimum three-day hospital stay within 30 days prior to the SNF admission and be in need of skilled nursing or rehabilitative services on a daily basis.

For payment purposes, Medicare separates SNF costs into routine, capital, and ancillary service categories. Medicare payments for routine costs, which include room, board, and skilled nursing services, are based on facility-specific costs, subject to an input price-adjusted national average per diem cost limit. Separate limits apply for hospital-based and freestanding facilities. These limits usually are updated each year, but were frozen for fiscal years 1994 and 1995. Capital costs and those for ancillary services, such as physical therapy, occupational therapy, speech therapy, laboratory

tests, and radiology procedures, are reimbursed on a facility-specific cost basis.³ Although most ancillary services are provided by SNFs and paid under Part A, there are situations when they are reimbursed under Part B.

Growth in Facilities, Utilization, and Expenditures—Between 1986 and 1994, the number of hospital-based SNFs increased by 163 percent, from 652 to 1,718 (see Table 4-6). The number of freestanding SNFs rose by 29 percent, while hospitals with SNF swing beds rose by 65 percent. During this period, many hospitals responded to declining average lengths of stay for Medicare beneficiaries and other patients by developing new lines of business, including hospital-based SNFs. Less restrictive state planning requirements for converting hospital acute-care beds to SNF beds contributed to their rapid growth.

Similar patterns are found in utilization and expenditures. In 1986, some 304,000 Medicare beneficiaries received care in skilled nursing facilities, and Medicare program payments totaled \$600 million (see Table 4-7). By 1994, 925,000 beneficiaries received SNF care, and payments reached \$8.3 billion. Numerous incremental legislative and administrative changes to SNF coverage and payment

Table 4-5. Medicare Rehabilitation and Long-Term Care Facility Payments, 1990-1993 (In Billions)

Facility Type	1990	1991	1992	1993*	Percent Change 1990-1993
Rehabilitation	\$1.9	\$2.4	\$3.1	\$3.7	95%
Long-term care	0.2	0.2	0.3	0.5	150

Note: Includes program payments and beneficiary payments. Does not include exceptions payments.

* Payments for facilities with cost reporting periods beginning on or after October 1, 1993, and before January 1, 1994, are estimated.

SOURCE: ProPAC analysis of Medicare Cost Reports and other data from the Health Care Financing Administration.

Table 4-6. Types of Medicare-Certified Skilled Nursing Facilities, Selected Years

Facility Type	1986	1990	1994	Percent Change 1986-1994
Hospital-based	652	1,145	1,718	163%
Freestanding	8,414	8,120	10,818	29
Swing-bed hospitals	812	1,243	1,342	65

SOURCE: Health Care Financing Administration, Office of Survey and Certification.

policies have contributed to utilization and payment growth. The most significant ones were a lawsuit that resulted in broadening SNF coverage guidelines in April 1988, along with the passage of the Medicare Catastrophic Coverage Act (MCCA) of 1988, and its repeal in 1990.⁴ The impact of these changes can be seen in the increase in Medicare-covered days and program payments in 1989, followed by a decrease in 1990. Although covered days have grown at an average annual rate of 10 percent since 1990, Part A program payments for SNF services have gone up even faster, at an average annual rate of 35 percent.

Some of the recent rise in Medicare program payments may be attributable to higher prices for inputs. Inflation alone, however, cannot account for the disparity between growth in use and payments. One source of the higher rise in payments has been the greater use of therapy and other ancillary ser-

vices provided to Medicare patients. In 1988, charges for physical, occupational, speech, and respiratory therapy services were about 15 percent of total Medicare SNF charges. By 1994, therapy services represented more than 30 percent of charges. Even though final payments for these and other ancillary services are based on costs rather than charges, these estimates suggest a large increase in their contribution to the overall growth of Medicare payments for SNF services.

Because of cost-based payment, greater ancillary use results in higher Medicare payments. Further, SNFs may cite high ancillary service use to justify an exemption from routine service cost limits, thereby increasing routine service payments.

Proposed Payment Changes—Many factors have contributed to the dramatic rise in Medicare expenditures for SNF services. The Congress and the President agree that the most appropriate long-term method for controlling SNF spending is to establish a comprehensive prospective payment system. Both have proposed legislation to do this. They differ, however, in their timing for implementing the comprehensive system and their methods for constraining Medicare payments under interim measures.

The Congressional Proposal—The Congress proposes significant changes to Medicare’s payment for skilled nursing facility services. It would

Table 4-7. Medicare Skilled Nursing Facility Payments and Utilization, 1983-1994

Year of Service	Skilled Nursing Facility		People Served		Days	
	Payments (In Billions)	Percent Change	Number (In Thousands)	Per 1,000 Enrollees	Number (In Thousands)	Per Person Served
1983	\$0.5	—	265	9	9,314	35.1
1984	0.6	6.9%	299	10	9,640	32.2
1985	0.6	2.9	314	10	8,927	28.4
1986	0.6	0.2	304	10	8,160	26.8
1987	0.6	8.8	293	9	7,445	25.4
1988	0.9	47.1	384	12	10,667	27.8
1989	3.5	275.7	636	19	29,780	46.8
1990	2.5	-29.0	638	19	25,200	39.5
1991	2.9	18.4	671	20	23,700	35.3
1992	4.5	55.3	785	22	28,960	36.9
1993	6.5	42.8	870	24	34,437	39.6
1994*	8.3	28.5	925	25	36,865	39.9

Note: Payments represent program liabilities incurred during the year and do not include beneficiary copayments.

* Estimated.

SOURCE: Health Care Financing Administration, Office of the Actuary.

require the Secretary of Health and Human Services to establish a prospective payment system for SNF services to be implemented on October 1, 1997. Under this system, a SNF would receive a fixed payment for each episode of care; the payment would cover all routine, nonroutine, and capital costs. Payment rates could vary by case mix, patient acuity, or any other appropriate factors. Aggregate payments, however, could not exceed 90 percent of what would have been paid under the current system. In addition, the prospective payment rates would be reduced to take into account beneficiary coinsurance.

An interim payment system for services provided on or after October 1, 1995, would be established until a prospective payment system was implemented. Since much of the recent growth in SNF spending is due to increased ancillary service use, payment for these services would be limited. Routine services would be subject to the per diem limits, and nonroutine services would be subject to facility-specific aggregate per stay cost limits. Nonroutine services would include all therapies, prescription drugs, complex medical equipment, intravenous therapy and solutions, radiation therapy, and diagnostic services. All other services, including some now considered ancillary, would be regarded as routine.

For fiscal year 1996 and beyond, the Secretary would recalculate the per diem routine cost limits, taking into account the expanded definition of routine services. To maintain the savings associated with the fiscal year 1994 and 1995 freeze on routine cost limits, any changes in the costs of services that occurred during these years would not be included in the new limits.

Payments for nonroutine services would be based on facility-specific costs, subject to facility-specific aggregate per stay cost limits.⁵ This would provide an incentive for SNFs to restrict ancillary service use while allowing for variation across facilities in costs related to patient mix and input prices. For fiscal years 1996 through 2002, Medicare payments for SNF capital costs would be reduced by 10 percent.

The congressional proposal would also require the Secretary to establish a separate per stay amount for patients who need intensive nursing or

therapy services and to implement an annual exceptions payment application period. In addition, Part B billing would be restricted, and SNFs would have to submit all claims for beneficiaries in their care. SNFs would be required to document on their Medicare Cost Report all nonroutine services provided to Medicare SNF patients, beginning in fiscal year 1996. This would include the number and type of therapy services, laboratory tests, and radiology and diagnostic procedures.

The Administration's Proposal—The Administration's proposal would also significantly alter Medicare payment for skilled nursing facility services. A prospective payment system for SNFs would be implemented beginning in fiscal year 1999. It would be based on fixed payments for all routine, ancillary, and capital costs. Budget-neutral rates would be calculated so that aggregate fiscal year 1999 payments would not exceed 93 percent of aggregate fiscal year 1998 payments.

Beginning in fiscal year 1997 and until the establishment of the comprehensive prospective payment system, SNFs would be reimbursed under an interim system. Payments for routine services would be based on facility-specific prospective per diem payment rates. They would be calculated using Medicare Cost Report data, adjusted to maintain the savings associated with the freeze on routine cost limits during fiscal years 1994 and 1995. These rates would be subject to regional limits, adjusted to reflect differences in input prices. Although these limits would be applied to all SNFs, they would be calculated using data for freestanding facilities only, rather than including hospital-based SNFs, which tend to have higher costs. The per diem rates could be adjusted to reflect changes in the mix of patients treated by a SNF. However, these adjustments would be made prospectively and in a budget-neutral manner.

Ancillary services would continue to be reimbursed on a facility-specific cost basis, but only up to the amount that would have been paid under the fee schedule rates used by Medicare to pay other facilities for similar services. Salaries for therapists who provide contracted services would be limited as well. Capital costs would continue to be reimbursed on a facility-specific cost basis.

Beginning in fiscal year 1997, SNFs could no longer receive exceptions payments for costs in

excess of their limits. In addition, new facilities would no longer be granted an exemption from routine cost limits for their first few years of operation. Prospective per diem payment rates for routine services in new facilities would be based on the mean payment for SNFs in the same geographic area. SNFs would also have to submit all claims for Part B services for their patients and use consistent coding.

Home Health Services

Beneficiaries qualify for home health services if they are homebound and under the care of a physician who prescribes part-time or intermittent skilled nursing services, physical therapy, or speech therapy. Once authorized, beneficiaries may receive an unlimited number of these qualifying services, as well as home health aide visits, medical social services, or occupational therapy. Coverage is not tied to a prior hospitalization, and no copayment is required.

Under Medicare's payment method for home health services, agencies are paid the lower of their aggregate costs or limits. The limits are equal to 112 percent of the average cost per visit for each of six types of visits, computed separately for rural and urban areas. The labor portion of each limit is adjusted by the hospital wage index. These cost limits are frozen for cost reporting periods beginning between July 1, 1994, and June 30, 1996. Because this payment method is largely cost-based, agencies have little incentive to control the cost or volume of services delivered.

Growth in Facilities, Utilization, and Expenditures—The increased availability of home health providers has contributed to the growth in use and Medicare expenditures for these services. The number of licensed agencies climbed by 50 percent between 1990 and 1995 (see Table 4-8). Freestanding proprietary agencies, which accounted for about half of all agencies in 1995, rose 65 percent. Hospital-based agencies also grew substantially, from 1,543 in 1990 to 2,346 in 1995.

Home health visits have increased dramatically in the last decade, from about 37 million in 1983 to 209 million in 1994 (see Table 4-9). The number of beneficiaries using home health climbed from 45 per 1,000 Medicare enrollees to 87 per 1,000

enrollees during this period. Use levels also surged from an average of 28 to 65 visits per person. Much of this increase is due to changes in coverage guidelines. These revisions allowed beneficiaries who needed part-time care (fewer than eight hours a day) or intermittent care (four or fewer days per week) to qualify for services. This expanded both the number of people receiving the benefit and the number of services used.

Home health episodes of care have also become longer. A home health episode is defined as a series of visits, preceded and followed by a period without visits. Using a gap of 60 days to define new episodes, the proportion of short episodes (those lasting 30 or fewer days) fell from 39 percent in 1990 to 32 percent in 1993 (see Table 4-10). Episodes lasting 121 days or longer went from 19 percent to 25 percent of all episodes. Longer episodes tended to include a higher proportion of the less costly home health aide visits. For example, 50 percent of the visits in very long episodes (those lasting at least 166 days) were aide visits, whereas aide services accounted for only 21 percent of the visits in short episodes (see Table 4-11). Further, compared with shorter episodes, longer ones were characterized by a higher proportion of aide visits throughout the episode.

Medicare's spending for home health services has grown at least 20 percent a year since the late 1980s. The rate of growth has declined, however, since the 53 percent spike in 1990. Still, home health's share of Medicare program expenditures has continued rising.

Proposed Payment Changes—The Congress and the Administration both have proposed establishing prospective payment systems for home health services. The congressional proposal would set prospective rates for each type of home health visit but limit total payments per episode, as of fiscal year 1997. By contrast, the Administration's proposal would establish episode-based payments effective in fiscal year 2000. Measures to limit spending in the intervening years also would be introduced.

In addition, both proposals would retain the savings from the two-year freeze on the cost limits and would make other interim modifications to the current payment system to reduce Medicare spending.

Table 4-8. Types of Medicare-Certified Home Health Agencies, 1990-1995

Agency Type	1990	1991	1992	1993	1994	1995	Percent Change 1990-1995
Visiting Nurse Association	476	515	595	596	575	570	20%
Government	981	1,089	1,240	1,205	1,208	1,191	21
Hospital-based	1,543	1,601	1,786	1,998	2,207	2,346	52
Rehabilitation facility-based	10	4	1	1	3	3	-70
Skilled nursing facility-based	105	90	106	117	127	145	38
Freestanding proprietary*	2,678	2,650	2,691	3,234	3,937	4,407	65
Total	5,793	5,949	6,419	7,151	8,057	8,662	50

* Includes a small number of freestanding, private, not-for-profit agencies that are not Visiting Nurse Associations (26 percent).

SOURCE: Health Care Financing Administration, Office of Survey and Certification.

The Congressional Proposal—The Congress proposes replacing cost-based payments with prospective rates for each of the six types of home health visits beginning in fiscal year 1997. These rates would be based on national average costs in cost reporting periods ending on or before June 30, 1994. They would be updated for each succeeding year by the home health market basket increase minus 2.0 percentage points. Rates would be recalculated using the most recent data every five years beginning in October 1999.

Total payments for the first 165 days of care would be limited to the lower of actual per visit payments or aggregated, episode-based limits. To determine the episode limits, visits would be aggregated into patient-level episodes of care. Each episode would be classified into one of 18 case-mix

categories. For each case-mix category, regional limits would be calculated based on the average cost of up to 120 days of care. Each agency's limit would equal the number of episodes it provided in each case-mix category times the regional case-mix limit.

Agencies with aggregate payments below their limit would receive an incentive payment equal to 50 percent of this difference up to 5 percent of their aggregate payments. Basing the payment limit on 120 days of care and sharing part of the payment difference would give agencies an incentive to reduce the number of services provided during an episode.

The episode limit would be applied to the first 165 days in an episode. The prospective payments for the subsequent visits in an episode would not be included in the episode-based payment limit. The

Table 4-9. Medicare Home Health Care Payments and Utilization, 1983-1994

Year of Service	Medicare		People Served		Visits		
	Payments (In Billions)	Percent Change	Number (In Thousands)	Per 1,000 Enrollees	Number (In Thousands)	Per 1,000 Enrollees	Per Person Served
1983	\$ 1.6	—	1,318	45	36,898	1,234	28
1984	1.9	17.5%	1,498	50	40,422	1,330	27
1985	1.9	4.0	1,549	50	39,449	1,274	25
1986	1.9	-0.5	1,571	50	38,000	1,204	24
1987	1.9	-1.2	1,544	48	35,591	1,104	23
1988	2.1	8.6	1,582	48	37,132	1,130	23
1989	2.6	23.8	1,685	50	46,199	1,379	27
1990	3.9	53.2	1,940	57	69,565	2,038	36
1991	5.7	44.2	2,223	64	100,044	2,875	45
1992	7.9	39.5	2,523	71	134,844	3,796	53
1993	10.7	34.6	2,900	80	173,953	4,804	60
1994*	13.0	22.1	3,220	87	209,149	5,765	65

Note: Payments represent program liabilities incurred during the year and do not include beneficiary copayments.

* Estimated.

SOURCE: Health Care Financing Administration, Office of the Actuary.

Table 4-10. Distribution of Home Health Episode Lengths, 1990 and 1993

Episode Length	Percent of All Episodes		Percent Change
	1990	1993	
All episodes	100%	100%	
Short	39	32	-7%
Medium	43	44	1
Long	19	25	6
121-165 days	5	—	—
166+ days	14	—	—

Note: Short episodes lasted 30 days or fewer; medium episodes exceeded 30 days but lasted fewer than 121 days; long episodes exceeded 120 days.

SOURCE: ProPAC analysis of 1990 and 1993 home health claims from the Health Care Financing Administration.

patient would, however, have to be certified as requiring continuing care. New episodes would begin after a period of 60 days without services.

The congressional proposal would also limit aggregate exceptions and exemptions payments to the amounts paid in fiscal year 1994, increased by the market basket percentage change for each year.

The Administration's Proposal—The Administration's proposal also would establish an episode-based

prospective payment system for home health services, but not until fiscal year 2000. The Secretary would develop both a prospective payment rate for an episode of care and a reliable case-mix adjuster in the interim. The episode payment amounts would be updated by the market basket. If a beneficiary received services from multiple agencies, each agency's payment would be prorated. Payment rates would incorporate a 15 percent reduction in cost limits that would be in effect on September 30, 1999.

The Administration's proposal also contains some interim changes to the payment system for fiscal years 1997 through 1999. Agency payments would be the lower of aggregate cost limits, agency-specific per beneficiary amounts, or actual costs. Cost limits would be reduced from 112 percent of the mean to 105 percent of the median. The per beneficiary amount would be determined by blending 1994 agency-specific costs with the national average cost. Alternatively, the Secretary could substitute a utilization measure in this formula. Agencies could receive bonus payments up to 5 percent of their aggregate payments if their costs or utilization were below 125 percent of the 1994 national average or regional aggregate experience.

Other changes would base payments on the service delivery area instead of the agency's geographic

Table 4-11. Number and Type of Home Health Visits, by Episode Length

Episode Length	Total Number of Visits	When Visits Occur in Episode	Mean Visits Per Episode	Share of Visits in Episode			
				Skilled Nursing	Aide	Physical Therapy	Other
Short	6,930,600	100%	9	60%	21%	15%	4%
Medium	35,158,905	100	33	49	31	16	3
First 30 days		72		50	29	16	6
Days 31-120		28		45	36	15	4
Long	10,139,625	100	74	47	38	11	4
First 30 days		37		49	33	12	6
Days 31-120		56		45	40	11	4
Days 121-165		7		46	42	9	3
Very Long	83,114,840	100	163	42	50	6	2
First 30 days		18		49	38	9	4
Days 31-120		29		43	47	7	3
Days 121-165		14		41	57	5	3
Days 166 or more		39		38	57	4	1

Note: Short episodes lasted 30 days or fewer; medium episodes exceeded 30 days but lasted fewer than 121 days; long episodes exceeded 120 days. These data are for episodes beginning between July 1, 1993, and June 30, 1994.

SOURCE: ProPAC analysis of 1990 and 1993 home health claims from the Health Care Financing Administration.

location. Interim payments, which currently are provided to home health agencies, would be eliminated. The proposal also would require that, beginning in fiscal year 1997, only the services provided during the first 100 days following a hospitalization would be paid under Part A. Visits after that period or any that were not associated with a hospital stay would be paid under Part B.

Conclusions and Recommendations

Both the Congress's and the President's proposals attempt to restrict the growth in Medicare's post-acute care spending. The average payment updates under the TEFRA payment system would be lower than those under current law. Skilled nursing and home health payments would be changed from cost-based reimbursement to prospective payment systems. Each proposal contains interim measures to restrict payments. However, neither one fully addresses the rising use of post-acute services. Following are the Commission's recommendations on the general approach to improve payments to post-acute providers and to help control the growth in Medicare spending.

Recommendation 20: Prospective Payment for Post-Acute Care

Prospective payment systems should be implemented for all post-acute services. The payment method for each service should be consistent across delivery sites. The Secretary should explore methods to control the volume of post-acute service use, such as bundling services for a single payment.

The post-acute care industry is characterized by substantial growth in the numbers of providers, people receiving services, and the services used by each recipient. These factors have contributed to the double-digit increase in Medicare's expenditures and the ever-larger share of Medicare payments for post-acute services. Some of this growth is due to site substitution between hospitals and post-acute providers. A large part of it, however, is due to the absolute increase in post-acute services provided to beneficiaries.

Prospective payment systems for post-acute services are needed to ensure that only necessary

services are provided and to improve Medicare's ability to track and compare service use. Further, broadening the payment unit to include all the services furnished during an episode of care would encourage providers to be more efficient. These payment changes, however, should be accompanied by mechanisms to make certain that facilities have the capacity to provide quality services appropriate to the patient's needs.

The Health Care Financing Administration (HCFA) has sponsored demonstration projects to develop prospective payment systems for skilled nursing facilities and home health agencies that have been in progress for several years. In addition, it is supporting research to develop prospective payment for rehabilitation services. Despite the overlap in the types of services delivered by each of these providers, the research projects have been managed, tested, and evaluated independently of each other. The Secretary should coordinate these efforts to develop consistent service units and prospective payment systems.

Recommendation 21: Case-Mix Measures for Post-Acute Services

Reliable case-mix measurement is important in prospective payment systems to account for resource use and to analyze treatment patterns and costs across sites. The Secretary should coordinate case-mix research across post-acute care settings, using consistent methods for measuring patient acuity and resource use.

Reliable case-mix measurement systems strengthen prospective payment by accounting for patient characteristics that affect resource use. Further, they allow for comparisons of service use and expenditures across beneficiaries and treatment settings. HCFA is sponsoring research to measure the intensity of services provided in rehabilitation, skilled nursing, and home health settings. It is essential that these studies be coordinated. Many of the same services, particularly nursing and therapies, are delivered by each of these providers, yet the units for measuring resource use differ in each demonstration. Thus, accurate comparisons of treatments or costs are not possible. HCFA should coordinate its efforts to produce a reliable system that consistently

classifies patients served and the number and types of services provided across delivery sites.

Recommendation 22: Interim Fee-for-Service Payment Method for Skilled Nursing Facility Services

An interim payment method should be implemented to control the growth in Medicare payments for SNF services until a comprehensive prospective payment system is established. A system based on historical data and facility-specific limits, however, may not allow facilities to respond appropriately to changes in a dynamic environment.

The Congress's and the President's proposals differ in their approaches to limiting Medicare payments for SNF services until a prospective payment system is implemented. They are similar, however, in that each would impose facility-specific and national limits. Both proposals would use Medicare Cost Report data, updated by the SNF market basket, to calculate limits or rates. Therefore, payments would reflect historical costs, patient mix, and treatment patterns. To account for the lack of a case-mix measurement system, the congressional plan would require the Secretary to develop a separate method for reimbursing SNFs for patients with intensive nursing or therapy needs. Likewise, the President's proposal would allow the Secretary to adjust the per diem rates to reflect changes in patient severity.

The Commission believes that interim payment limits should be designed to provide appropriate constraints on Medicare outlays without unduly restricting this evolving industry. Facility-specific limits would allow SNFs that had high costs during the base year to maintain higher payments year after year, while those that experienced low costs during the base year would be restricted to these lower levels. On the other hand, payment limits based on average costs would not reflect legitimate cost differences across facilities. Further, historical data would not account for the higher costs associated with the changing acuity of SNF patients. Alternative methods for calculating payment limits, such as using a larger geographic area or blending facility-specific and national rates, should be explored.

Recommendation 23: Interim Fee-for-Service Payment Method for Home Health Care

Until a fully prospective payment system is developed, the Commission supports adopting episode-based payment limits. In addition, beneficiary copayments, subject to an annual limit, should be introduced.

The Commission recognizes that a prospective payment system for home health care will take time to implement. In the interim, other mechanisms should be established to constrain the growth in service use. Instituting episode-based payment limits, as proposed by the Congress and the Administration, would encourage providers to deliver services more efficiently. In addition, adopting copayments would increase beneficiaries' involvement in home health treatment decisions, consistent with their financial responsibility for other Medicare-covered services. Beneficiary out-of-pocket costs should be limited, however, so that the copayments do not restrict access inappropriately. Further, Medicare needs to explore other means, such as case management and utilization review, to control use.

In developing prospective payment rates, characteristics of the current home health delivery system should be considered. Units of service are not uniformly defined across agencies. Consistent definitions would allow the Secretary to better monitor and evaluate Medicare's expenditures and quality of care. In addition, both the Congress and the President propose blending national and regional costs to establish payment limits. While the Commission believes these proposals would improve the current cost-based system, it is concerned that maintaining regional variation in the limits would perpetuate unjustified differences in utilization and expenditures. ProPAC supports a transition from regional to national rates, as was used in establishing hospital prospective payment rates, to eliminate this type of unexplained variation.

AMBULATORY CARE PROVIDERS

Medicare spending for ambulatory care, whether furnished in outpatient facilities or in physicians' offices, increased from 30 percent of total program expenditures in 1983 to 32 percent in 1994. Part B payments to outpatient facilities alone reached

\$14.1 billion in 1994.⁶ Outpatient care is provided in hospital outpatient departments, freestanding ambulatory surgical centers, independent clinical laboratories, comprehensive outpatient rehabilitation facilities, and hospital-based and freestanding dialysis centers. However, 85 percent of Medicare outpatient spending goes to hospital outpatient departments and dialysis centers. This section focuses on services provided by these facilities.

Outpatient Dialysis Services

The 1972 amendments to the Social Security Act extended all Medicare Part A and Part B benefits to people with end-stage renal disease (ESRD). Virtually all patients of any age who are diagnosed with ESRD are eligible. ESRD is marked by the irreversible loss of kidney (renal) function. It is treated either with organ transplantation or permanent renal dialysis. The vast majority of ESRD enrollees are treated with either hemodialysis or peritoneal dialysis on an outpatient basis.⁷ Consequently, there is a strong incentive for these beneficiaries to purchase Part B coverage.

Benefits for a kidney transplant patient generally start the month in which the transplant is performed, whereas dialysis benefits generally begin three months after eligibility is established. For an ESRD enrollee who also is covered by an employer-sponsored group health plan, all medical claims during the first 18 months of Medicare eligibility are paid first by the employer's plan. If the employer's plan does not pay in full, Medicare will make secondary payments up to its specified limits or the billed amount, whichever is lower. This is known as the Medicare secondary payer provision.

Most dialysis patients receive hemodialysis in either hospital-based or freestanding dialysis centers. Others dialyze at home under the supervision of a local facility. When coverage for ESRD patients began, Medicare paid hospital-based and freestanding dialysis providers their reasonable costs and reasonable charges, respectively, limited to \$138 per treatment. Beginning in 1983, the payment methodology was changed to a prospective rate per dialysis treatment.

The prospective payment, called the composite rate, covers the bundle of services, tests, drugs, and supplies routinely required for a dialysis treatment

(hemodialysis or peritoneal dialysis) whether it is provided in a facility or performed by the beneficiary at home. It represents the national median cost per treatment, weighted by the percentage of patients dialyzing in each site.

The composite rate was calculated in 1983 based on a sample of Medicare Cost Reports from 1977 through 1979. Therefore, it reflects the mix and costs of inputs and the proportion of patients dialyzing in different sites at that time. The labor portion of the base rate is adjusted for geographic differences in wages; however, payments may not exceed \$139 per treatment.⁸ Hospital-based facilities receive a slightly higher composite rate than freestanding facilities.

Unlike Medicare payments to other types of providers, the composite rate has not been updated annually. Aside from a \$2 decrease implemented in 1986 and a \$1 increase in 1991, the composite rates have not changed. When accounting for inflation, therefore, the real payment per treatment has declined substantially. The Omnibus Budget Reconciliation Act (OBRA) of 1990 requires ProPAC to examine the payment for dialysis services and recommend an update factor each year.

Even though the composite rate has changed very little since it was implemented, total Medicare payments to dialysis facilities have increased rapidly. This is largely due to a 10 percent annual growth in the number of beneficiaries receiving dialysis. Rising use of certain extra billable dialysis-related items, among them nonroutine drugs and some diagnostic and laboratory tests, has contributed as well.

Moreover, aggregate Medicare expenditures for all beneficiaries with ESRD (including transplant recipients) have escalated, from 3.8 percent of total program payments in 1985 to 5.0 percent in 1994. This includes spending for acute and post-acute care for other conditions in addition to dialysis-related services. Consequently, aggregate payments per ESRD enrollee rose from \$28,158 to \$39,431 during this period, while the size of this group grew rapidly (from 0.3 percent of the Medicare population to more than 0.6 percent). In 1994, Medicare payments per person with ESRD were almost nine times greater than for other beneficiaries. This reflects the high annual cost of dialysis as well as the high overall morbidity of these patients.

Proposed Payment Changes—Neither the Congress's nor the President's proposal includes an update to the composite rate. Both would, however, extend the Medicare secondary payer provision. Under current law, the 18-month period will revert to 12 months on October 1, 1998. The President proposes to set it at 18 months indefinitely. The Congress would permanently extend it to 30 months.

While these proposals would not affect the composite rate payment methodology, they would achieve savings for the Medicare program. The exact amount of savings is uncertain, but it could be substantial. When the Medicare secondary payer provision was extended from 12 to 18 months (under OBRA 1990), the General Accounting Office (GAO) estimated that Medicare would shift \$87 million to employer plans each year.⁹ In addition, GAO estimated that dialysis providers would receive \$41 million more annually. This is because most private health plans pay on the basis of charges, which generally are substantially higher than Medicare's composite rate.

Update Framework—Dialysis providers have continued to treat a growing Medicare ESRD population, even though the inflation-adjusted payment rate has declined substantially. Moreover, freestanding facilities have prospered, largely because of dramatic gains in productivity that lowered service costs. Between 1983 and 1987, facilities achieved substantial productivity improvements through changes in staffing patterns, the use of high

flux and high efficiency dialysis (which led to shorter dialysis sessions), dialyzer reuse, and price discounts from suppliers.¹⁰ Scientific and technological advances, on the other hand, raised per treatment costs by 0.8 percent annually, on average.

Between 1987 and 1991, however, productivity gains had a much smaller effect on the cost per hemodialysis treatment (although still greater than that for scientific and technological advances). During this period, treatment sessions became more intensive, requiring more sophisticated techniques and equipment and a richer mix of staff to monitor patient outcomes. Scientific and technological advances continued to increase per treatment costs, but only by about 0.2 percent annually.

More recent data show that dialysis facilities' costs are rising, though more slowly than inflation in the goods and services they purchase. Medicare costs for both hemodialysis and peritoneal dialysis in hospital-based facilities increased, on average, by 1.4 percent per year from 1991 to 1994. By contrast, ProPAC's market basket index for hospital-based facilities averaged 3.3 percent annual growth over the same time.¹¹ Medicare costs in freestanding facilities rose by 2.2 percent annually from 1991 to 1993, compared with a 3.7 percent average market basket increase.¹²

On average, Medicare costs in hospital-based facilities were about 45 percent higher in 1994 than those in freestanding facilities. Aggregate Medicare payments to hospital-based facilities covered only

Table 4-12. Payment to Cost Ratios for Hospital-Based and Freestanding Dialysis Facilities, All Dialysis Treatments, 1990-1994

Hospital Category	Hospital-Based Facilities					Freestanding Facilities				
	1990	1991	1992	1993	1994	1990	1991	1992	1993	1994
All	0.86	0.80	0.80	0.77	0.77	1.12	1.13	1.11	1.08	1.05
Rural	0.85	0.79	0.77	0.78	0.78	1.10	1.09	1.07	1.02	0.98
Urban	0.86	0.80	0.80	0.76	0.76	1.12	1.14	1.12	1.09	1.06
Nonprofit	0.85	0.80	0.80	0.77	0.77	1.08	1.06	1.03	1.04	1.05
Profit	1.00	0.85	0.85	0.68	0.68	1.13	1.15	1.13	1.09	1.05
Small	0.72	0.72	0.71	0.64	0.64	1.04	1.04	1.02	0.97	0.92
Medium	0.85	0.77	0.77	0.75	0.75	1.12	1.11	1.09	1.06	1.02
Large	0.91	0.85	0.85	0.80	0.80	1.15	1.18	1.16	1.13	1.10

Note: 1994 ratios are based on estimated payments and costs for freestanding facilities. Includes both hemodialysis and peritoneal dialysis treatments.

SOURCE: ProPAC analysis of Medicare Cost Report data from the Health Care Financing Administration.

77 percent of reported costs (see Table 4-12). By contrast, Medicare payments were approximately 5 percent above freestanding facilities' reported Medicare costs.¹³ For both types of providers, larger facilities (those that treated the highest volumes of patients) had lower costs per treatment and therefore better financial performance.

It appears that freestanding dialysis facilities in particular—which account for about 64 percent of all facilities and serve about 69 percent of all dialysis patients—performed well through 1994. As the costs of providing dialysis services have slowly risen, however, Medicare payment to cost ratios have gradually declined. Additionally, cost report data suggest that facilities recently have achieved only modest cost savings through productivity improvements (see Table 4-13). In 1994, hemodialysis treatments per station and total treatments per full-time equivalent employee were no longer increasing as they had in the past, while staffing mix was stable.

Some observers are concerned that continued attempts to achieve productivity gains—primarily through shorter dialysis sessions—may adversely affect the quality of care provided to Medicare ESRD beneficiaries. Adjusted survival rates have improved among dialysis patients in recent years, despite the fact that they are older and sicker than before.¹⁴ Survival has increased for all age, race, ethnic, and diagnosis groups, as well as for all

dialytic modalities. But rates still may not be as high as they should.

A measure of dialysis adequacy is Kt/V (the fraction of a patient's total body water cleared of urea during a dialysis session).¹⁵ Recent studies have found that almost 50 percent of hemodialysis patients had a Kt/V of less than 1.0, placing them at higher risk for morbidity and mortality. One reason may be that many patients are not dialyzed long enough. Treatment times fell, on average, from 15 to 18 hours a week in the 1970s to 12 to 15 hours a week in the 1980s. During the early 1990s, average lengths of hemodialysis slipped even further, although recently they have begun to rise. Improved technology may account for shorter treatment times, but economic incentives to save on labor and capital costs as well as patient preferences also contribute to the phenomenon.

Mortality rates for dialysis patients generally are believed to be greater in the United States than in Europe or Japan. Studies have found that the higher mortality in this country cannot be explained by differences in patient age, gender, race, or the presence of diabetes. These studies, however, continue to be limited by inadequate measures of patient severity.

More definitive studies are needed, but recent evidence suggests that treatment factors heavily influence mortality rates. For example, prescribed

Table 4-13. Median Productivity Indicators for Hospital-Based and Freestanding Dialysis Facilities, 1990-1994

Facility Type	Total Treatment Per FTE	Staff Mix	Hemodialysis Treatments Per Station	Length of Dialysis (In Hours)	Dialyzer Reuse
Hospital-based					
1990	550	0.67	599	4.5	—
1991	561	0.64	618	4.5	—
1992	563	0.64	621	4.5	—
1993	587	0.63	645	4.5	—
1994	588	0.63	642	4.5	—
Freestanding					
1990	659	0.33	539	4.5	9.1
1991	625	0.35	555	4.5	10.0
1992	633	0.34	566	4.5	11.2
1993	617	0.35	563	4.5	12.0

Note: 1994 data are not available for freestanding facilities. FTE = full-time equivalent. Staff mix = ratio of registered nurses to all direct patient care staff, including registered and licensed practical nurses, nursing assistants, and technicians. Dialyzer reuse measures average number of times dialyzers are reused.

SOURCE: ProPAC analysis of Medicare Cost Report data from the Health Care Financing Administration.

Kt/V in Europe appears to be higher than in the United States, and dialyzer reuse—which may decrease urea clearance—is less common in other countries.¹⁶ Nations also differ in the extent to which they use in-facility hemodialysis, which has been associated with a lower survival rate compared with peritoneal dialysis. Even within the United States, the relative use of these modalities varies among facility types. This reinforces the concern that treatment variation may be driving differences in mortality rates.

ProPAC's ongoing analysis of dialysis costs indicates that input prices can be expected to rise by about 3.2 percent between fiscal years 1996 and 1997. Scientific and technological advances are expected to increase per treatment costs by 0.7 percent over the same period.¹⁷ Although this industry is not likely to repeat the marked productivity improvements experienced in the 1980s, the Commission believes that gains consistent with the hospital industry can be achieved.

Despite rising costs and declining financial performance, the number of dialysis providers continues to grow by about 6 percent per year. This may reflect the continued increase in the number of ESRD beneficiaries. However, freestanding facilities—particularly proprietary ones—have grown by about 9 percent annually, a rate much faster than that for hospital-based providers.

Many industry experts have raised concerns about whether this industry can continue to provide quality dialysis services without higher payments. There is no conclusive evidence that the quality of care has actually declined or that there are quality differences across facility types. Nonetheless, recent studies indicate that a substantial percentage of hemodialysis patients in the United States may be underdialyzed and that treatment is a major factor affecting patient outcomes. If facilities must extend treatment times to ensure that Medicare patients receive adequate dialysis, their costs are likely to increase further.

Hospital Outpatient Services

Medicare payments for many hospital outpatient services are based at least partially on the providers' reasonable costs of furnishing the service. For certain ambulatory surgeries, radiology services, and diagnostic procedures, the total payment is the lowest of

the hospital's reasonable costs, charges, or a blended amount that combines the lesser of costs or charges with a prospective payment amount for the same service in another setting. Payment for some other services, such as clinic and emergency room visits, is the lesser of the hospital's costs or charges. Still others (laboratory tests, for example) are paid for using a fee schedule, without regard to the provider's actual costs.

The use of multiple payment methods not only creates conflicting incentives for hospitals, but imposes an administrative burden. Moreover, different payment methods and amounts are applied for the same service across sites of care. This may inappropriately influence the choice of treatment setting.

In addition, cost-based payment methods provide weak incentives to constrain the cost and volume of services furnished. As a result, Medicare outlays for hospital outpatient services have increased rapidly. In response, the Congress mandated in OBRA 1990 that the Secretary of Health and Human Services develop a prospective payment system for hospital outpatient services. The Secretary's report, released in 1995, recommended implementation of prospective payment in several phases.¹⁸ In its response to that report, the Commission expressed concern about several issues.

First, if prospective payment were implemented on an incremental basis, hospitals and Medicare would bear the costs associated with adopting a new payment system while receiving few of the desired benefits. Partial implementation would do little to promote simplicity or predictability of payment, or to reduce the administrative burden on hospitals or the program. Such a policy also would create opportunities for providers to increase their revenues by altering billing practices or reallocating overhead costs to services that remain under cost-based payment. Second, even a comprehensive prospective payment system would retain fee-for-service payment, with little incentive for providers to control the burgeoning volume of services.

Given these concerns, the Commission recommended that the incremental hospital outpatient prospective payment system proposed by the Secretary not be enacted. ProPAC continued to support the concept of a comprehensive payment system

for hospital outpatient services, but recommended that the Congress require the Secretary to submit a fully detailed legislative proposal for implementing such a system. In addition, the Commission recommended coupling prospective payment with a strategy to control the growth in overall outpatient service volume. As most outpatient services can be provided in multiple settings, imposing volume controls only on hospital outpatient services probably would shift them to other sites.

Beneficiary Liability—Because Medicare payments for hospital outpatient services are based partially on costs, final payments are not known until providers' annual cost reports are settled. Consequently, under current law, the beneficiary copayment is set at 20 percent of charges rather than 20 percent of the total payment, as it is for other Part B services.

Basing copayments on hospital charges results in savings to the Medicare program. Since beneficiary liability is subtracted from the total payment to determine Medicare's contribution, rising copayments defray some program spending. At the same time, however, charge-based copayments impose an ever-greater financial burden on Medicare enrollees who use hospital outpatient services. Moreover, this burden is increasingly uneven across types of services and settings.

According to the most recent estimates, beneficiaries are responsible, on average, for 37 percent of the total payments to hospitals for Medicare-covered outpatient services. For certain surgeries, radiology, and diagnostic procedures, beneficiaries pay about 53 percent of the total. For other cost-based outpatient services, it is about 30 percent. These shares are considerably higher than if the same services were provided in other ambulatory settings.

These differences in cost sharing unfairly penalize beneficiaries who receive care in hospital outpatient facilities. In addition, they provide strong incentives for physicians, acting on behalf of patients, to choose a site of care on the basis of financial considerations rather than clinical appropriateness. These incentives are mitigated for many beneficiaries because they have supplemental insurance policies or are eligible for Medicaid benefits that cover most copayments. About 11

percent of Medicare beneficiaries, however, lack such coverage. Those who have private policies indirectly carry the growing burden of cost sharing through rising insurance premiums. Setting beneficiary copayments at 20 percent of payments instead of 20 percent of charges would increase program spending, but would eliminate this source of adverse incentives and growing inequity in the payment burden.

Formula-Driven Overpayment—Medicare's share of the payment for certain ambulatory surgeries, radiology services, and some diagnostic services is supposed to be the total amount minus the beneficiary copayment. For facilities paid the blended amount, however, program payments are not reduced by the entire copayment.¹⁹ Thus, total payments to hospitals for outpatient services are higher than the Congress intended. In addition, this problem with the formula provides a strong incentive for hospitals to raise charges, which increases beneficiary liability and total payments to hospitals.

ProPAC previously recommended changing the formula so that the beneficiary copayment is subtracted after the total amount is calculated. This correction would result in savings for Medicare, which should be used to offset spending increases caused by reducing beneficiary copayments.

Proposed Payment Changes—The Congress's proposal would correct the formula-driven overpayment in a manner that is consistent with past ProPAC recommendations. However, it does not address prospective payment for hospital outpatient services or the issue of beneficiary liability. The President's proposal contains no provision regarding Medicare payment for hospital outpatient services.

Conclusions and Recommendations

The Commission's analyses of Medicare policies regarding ambulatory care providers have focused on dialysis facilities and hospital outpatient departments not only because of ProPAC's statutory obligations, but also because these facilities account for the vast majority of Medicare outpatient spending. In making recommendations, however, the Commission is mindful of how changes to Medicare's payment policies will affect other ambulatory care providers and expenditures for other services.

Recommendation 24: Update to the Composite Rate for Dialysis Services

The Secretary should develop methods to control total Medicare per capita expenditures for ESRD beneficiaries. In the meantime, the composite rate should be updated by 2.7 percent for hospital-based dialysis facilities and by 2.0 percent for freestanding facilities for fiscal year 1997. The Secretary should also develop reliable measures of patient severity and outcomes to analyze the relationships among treatment processes, patient outcomes, and costs. These factors should be considered in evaluating the need for and the level of future payment updates.

The rapid growth in total Medicare spending for ESRD beneficiaries is a major concern. A large part of this increase is due to an expanding ESRD population. But these beneficiaries are also using more acute inpatient, skilled nursing, home health, and dialysis-related services than ever before. A comprehensive payment method that encompasses a broader set of services should be explored. Capitation has been successful in controlling expenditure growth for other populations. Most ESRD beneficiaries, though, are not eligible to enroll in the Medicare risk program. The Secretary should either open enrollment to this group or consider implementing a separate capitation program. At a minimum, utilization review or other managed care techniques should be used to control the total volume of services provided to ESRD beneficiaries across all sites of care.

Until major policy changes are made, Medicare should consider the adequacy of its current payment rates. Unlike program payments to other types of health care providers, the composite rate for outpatient dialysis services is not updated annually. That Medicare treats dialysis facilities differently is of some concern. This is heightened by the fact that neither the Congress's nor the President's proposal contains a provision to update the composite rates. Under these proposals, dialysis facilities would not receive payment increases for the next seven years.

Dialysis facilities have treated a growing Medicare ESRD population, even though the inflation-adjusted payment rate has declined substantially. The Medicare

program is responsible for making certain that payments for services furnished to its beneficiaries are adequate to ensure quality care. Recent evidence suggests that input costs are rising and that large productivity gains may no longer be possible. Consequently, these facilities may be unable to continue to provide quality dialysis services without a payment rate increase. Given widespread concern about the quality of dialysis services, the composite rate should be updated as suggested by ProPAC's update framework. Differential updates would help to account for cost differences between hospital-based and freestanding facilities. Further, the Secretary should closely monitor treatment patterns and patient outcomes to ensure that facilities use the payment increase to improve quality of care.

Recommendation 25: Prospective Payment for Hospital Outpatient Services

A comprehensive prospective payment system should be developed for hospital outpatient services. Such a system should include a strategy for controlling the volume of ambulatory services.

A prospective payment system for all hospital outpatient services should be implemented as soon as possible. Prospective payment would create incentives for controlling costs by offering providers the opportunity for profits as well as the risk of financial loss. Because almost all services provided in the hospital outpatient setting can be obtained in other ambulatory settings, the Secretary should strive to create consistent payment policies across all sites and providers.

ProPAC analyses indicate that much of the rise in Medicare spending for outpatient services is due to rapid increases in utilization. To constrain future growth in outpatient service use, a strategy for limiting use should be developed. Imposing volume controls on hospital outpatient services only, however, probably would lead to a shift in use to other sites. Ultimately, therefore, volume control methods should apply to all ambulatory care settings.

Recommendation 26: Beneficiary Liability for Hospital Outpatient Services

The growing financial burden for Medicare enrollees who receive services in hospital

outpatient departments should be alleviated immediately. Beneficiary coinsurance for these services should be limited to 20 percent of the Medicare-allowed payment, as it is in other settings. For services not paid on a prospective basis, the Secretary should establish a new method for determining beneficiary copayments based on estimated allowed payments since they cannot be calculated precisely when services are delivered.

Under current law, the beneficiary's copayment for hospital outpatient services is 20 percent of charges rather than 20 percent of the total payment, as it is for virtually all other Part B services. Because hospital charges generally are higher than total payments, beneficiaries are responsible for substantially more than 20 percent of total payments. In addition, because hospitals' charges have grown more rapidly than total payments, beneficiary cost sharing has increased disproportionately. If this continues, the beneficiary's share of outpatient payment soon will overtake the program's share.

Beneficiary liability for hospital outpatient services is higher than it would be if the services were provided in another setting. Such differences in cost sharing unfairly penalize beneficiaries who receive care in hospital outpatient facilities.

Until a prospective payment system is implemented, copayments should be based on estimated payments. This could be done in several ways. Copayments could equal a lower percentage of charges, for example. Alternatively, HCFA could use an estimate of each hospital's payment to charge ratio, to determine the coinsurance amount for each service.

Reducing beneficiary coinsurance would raise Medicare outlays. The Commission therefore recommends that the reduction in program payments resulting from correcting the blended payment formula, as specified in the Congress's proposal, partially offset this increase. If necessary, the change in beneficiary liability could be phased in over several years.

Notes to Chapter 4

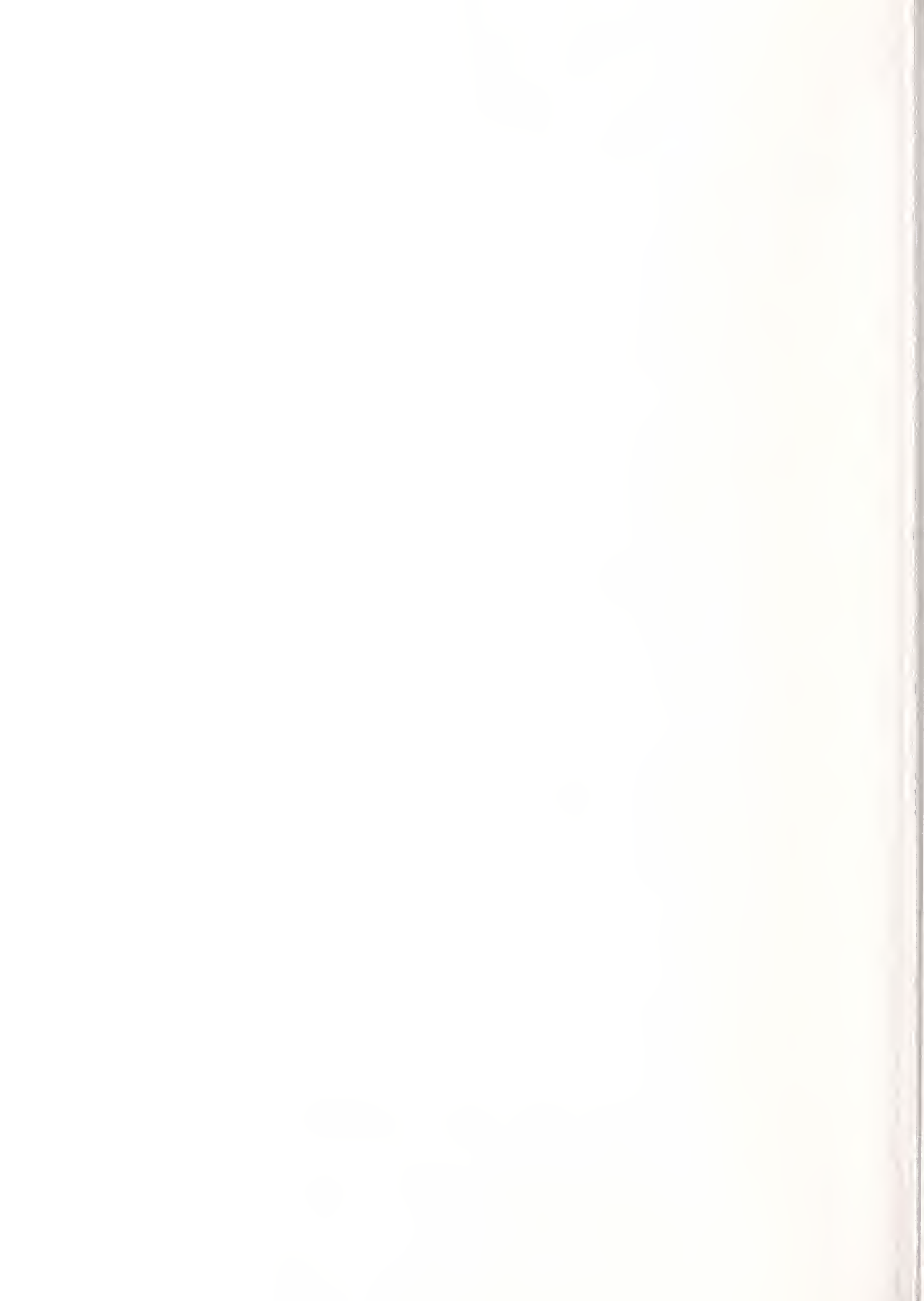
1. The Medicare provisions passed by the Congress are in H.R. 2491, the "Balanced Budget Act of 1995." The Medicare provisions of the President's proposal are in Title II of draft legislation, called the "Balanced Budget Act of 1995 for Economic Growth and Fairness." Released on December 7, 1995, it has not been introduced in the Congress.
2. Rehabilitation and psychiatric distinct-part units newly certified by Medicare are exempt from TEFRA limits only for their first full 12-month cost reporting period. The first full year of operation is designated as the base year for these facilities.
3. The only restriction on ancillary service costs, other than meeting Medicare's definition of reasonableness, is that when physical and respiratory therapy services are provided "under arrangement" by an external facility, the therapists' salaries must be below HCFA's state-level salary guidelines.
4. In the lawsuit, *Fox v. Bowen*, 656 F. Supp. 1236 (D. Conn. 1986), the Court held that the Secretary's practice of using arbitrary rules to deny physical therapy benefits delivered by SNFs violated Medicare statutes and regulations and the due process clause of the U.S. Constitution. MCCA removed the prior hospital stay requirement, decreased the SNF copayment, and broadened coverage by changing the maximum benefit to 150 days per year.
5. The nonroutine cost limits would be calculated by determining the average costs *per stay* of nonroutine services during the last (12-month) cost report submitted on or before December 31, 1994. This amount would then be updated by the SNF market basket to fiscal year 1996 and multiplied by the number of stays that the SNF had during the year. Per stay amounts would be updated by the SNF market basket minus 2 percentage points in fiscal year 1997 and in each subsequent year until the implementation of the prospective payment system. Estimates of Medicare Part B payments for SNF services provided to beneficiaries eligible for Part A during the 1994 cost reporting period would be included in the facility-specific limits. In addition, facilities that did not submit a cost report in 1994 would be assigned *per stay* limits based on the national average cost for non-routine services.
6. Health Care Financing Administration, Office of the Actuary.
7. As the number of kidney transplants performed and graft survival rates has risen over time, the proportion of all Medicare ESRD beneficiaries with a functioning transplant has increased—from 10.8 percent in 1978 to 22.0 percent in 1991. Still, dialysis patients accounted for a large majority of ESRD enrollees in 1991.
8. The payment limit was increased to \$139 under OBRA 1990.
9. U.S. Congress, General Accounting Office, *Medicare: Impact of OBRA-90's Dialysis Provisions on Providers and Beneficiaries*, GAO/HEHS-94-65 (Washington, DC: U.S. Government Printing Office, April 1994).
10. Project HOPE's Center for Health Affairs, *Identifying Changes in the Factors of Production for Dialysis Services*, ProPAC Extramural Technical Report, No. E-93-01, March 1993.
11. ProPAC's dialysis facility market basket contains four cost components—capital, labor, other direct costs, and overhead. Because cost shares for these components differ for hospital-based and freestanding facilities, the Commission developed separate market baskets. Price proxies were derived from the components of HCFA's input price indexes for PPS hospitals, skilled nursing facilities, and home health agencies.
12. HCFA introduced a new cost report for freestanding dialysis facilities effective for cost reporting periods beginning on or after October 1, 1993 (fiscal year 1994 and after). The revised cost report corrects for certain errors that led to data quality problems. Unfortunately, the 1994 data for these facilities were not available for ProPAC's analysis.

13. The composite rate is intended to cover the portion of facility costs that is allowable in accordance with Medicare principles of reimbursement. HCFA's audit of fiscal year 1991 cost reports found that Medicare-allowable costs in freestanding dialysis facilities were 12.2 percent lower than reported costs, whereas those in hospital-based facilities were 4.6 percent lower. After adjusting reported costs by HCFA's audit correction factors, payment to cost ratios are substantially higher.
14. Project HOPE's Center for Health Affairs, *Quality of Dialysis in the United States*, ProPAC Extramural Technical Report, forthcoming.
15. Kt/V (where K is the dialyzer clearance of urea, t is the time of dialysis, and V is the patient's urea volume) measures the intensity of dialysis relative to the patient's size, describing the fractional removal of urea.
16. Past studies found that inadequate manual reprocessing of dialyzers was associated with a higher risk of morbidity and mortality, although this no longer appears to be a problem.
17. Each year, ProPAC estimates how Medicare costs are affected by the dialysis industry's adoption of new cost-increasing, quality-enhancing scientific and technological advances. The Commission's most recent analysis indicates that these innovations will raise facilities' total operating and capital costs by \$26.6 million, or 0.7 percent, in fiscal year 1997. Abt Associates, *The Incremental Impact of Scientific and Technological Advances on Cost Increases in Dialysis Facilities*, ProPAC Extramural Technical Report, No. E-96-01, January 1996.
18. U.S. Department of Health and Human Services, *Report to Congress: Medicare Hospital Outpatient Prospective Payment*, March 17, 1995.
19. The blended amount is determined by a two-part formula: the hospital-specific portion (the lesser of costs or charges minus 20 percent of charges) and the prospective portion (80 percent of the applicable prospective rate). The prospective rate for ambulatory surgery is the amount for the relevant procedure category used to pay freestanding ambulatory surgical centers. For radiology and diagnostic services, it is that portion of the physician fee schedule intended to represent the technical expense of providing that service.

The second part of the formula inappropriately assumes that 20 percent of the prospective rate equals 20 percent of charges (the copayment). In fact, charges are usually much higher than the prospective rate. Because the full contribution of beneficiary cost sharing is not captured, Medicare's share of hospital payments is overstated.



Appendixes



Appendix A. Technical Report Series

Appendix A lists the Prospective Payment Assessment Commission's (ProPAC's) extramural and intramural technical reports. These reports provide documentation related to the Commission's March and June annual reports to the Congress. The congressional reports are prepared upon request by the Congress. Each technical report is numbered according to type and year of publication. Numbers missing from the sequence refer to studies that have been replaced with more recent reports. Commission reports can be obtained from the Prospective Payment Assessment Commission, 300 7th Street, S.W., Suite 301B, Washington, D.C. 20024, or by calling the office at 202/401-8986.

EXTRAMURAL TECHNICAL REPORT SERIES

E-87-01: Improving the Definition of Hospital Labor Market Areas and Wage Indexes (Abt Associates, Inc.)

Methods for improving the definition of hospital labor market areas were investigated. This report identifies urban and rural labor market areas with the greatest amount of wage variation. It also examines the sources of wage variation within current labor markets and possible improvements in the area wage adjustment. Appended are step-by-step instructions for assigning hospitals within metropolitan statistical areas to urbanized areas as defined by the Bureau of the Census. (formerly E-87-12)(2/87)

E-87-03: Measures of Complexity of Illness Within DRGs (SysteMetrics/McGraw-Hill, Inc.)

The goal of this research was to refine the Commission's method of monitoring continuing changes in DRG case mix and case complexity (changes within DRGs). This study refines the Commission's methodology for estimating the annual component of real case-mix change within DRGs. The methodology was used to develop annual estimates of within-DRG case-mix change for Medicare patients from 1984 to 1986. It was also used by the Commission to estimate this component of real case-mix change in future years as additional

Medicare data became available. Estimates from this study were used to analyze the indirect medical education adjustment. (3/89)

E-87-06: Assessing the Adequacy of the Medicare Cost Report Data (SysteMetrics/McGraw-Hill, Inc.)

This report provides information on perceived strengths and weaknesses of the Medicare Cost Report. Hospital financial officers, fiscal intermediaries, and industry representatives were surveyed. In general, the results of this study indicate that most hospitals believe that the cost report is acceptable as a reimbursement tool. Most hospitals thought, however, that the cost report does not accurately measure the cost of care for Medicare beneficiaries because bad debt, charity care, patient telephones, and so forth are not recognized. PPS has resulted in changes in reporting practices. Particular attention is given to passthrough items like capital and direct medical education. (4/88)

E-87-08: Trends in the Concentration of Six Surgical Procedures Under PPS and Their Implications for Patient Mortality and Medicare Cost (Project HOPE)

This report examines trends in hospitals' volumes of six specialized surgical procedures and the impact of those trends on mortality and costs. The six procedures are coronary artery bypass grafting, total hip replacement, abdominal aneurysm repair, intestinal resection, transurethral prostatectomy, and carotid endarterectomy. (6/88)

E-87-11: Small Isolated Rural Hospitals: Alternative Criteria for Identification in Comparison with Current Sole Community Hospitals (SysteMetrics/McGraw-Hill, Inc.)

This study determines how many facilities become eligible for sole community hospital (SCH) status. The contractor also examines how the distribution of SCHs would change if the SCH criteria were altered. This study also provides information used to analyze the financial vulnerability of small isolated rural hospitals. (6/88)

E-88-01: Subacute Care in Hospitals: Synthesis of Findings from the 1987 Survey of Hospitals and Case Studies in Five States (Lewin/ICF)

This document is the final report of an 18-month study of subacute care in hospitals, often referred to as transitional care. Results of a representative national survey of hospitals are presented, along with findings from case studies in five states (California, Louisiana, New York, North Carolina, and Washington). Information is also presented on other types of transitional care, such as home health and skilled nursing care. (9/88)

E-88-02: An Analysis of Hospital Sensitivity to DRG Price Variation in the Medicare Prospective Payment System (SysteMetrics/McGraw-Hill, Inc.)

This study provides information on whether hospital behavior in rendering care and assigning resources is sensitive to differences between hospital costs and PPS prices. The contractor interviewed health care consultants and hospital administrators to identify the extent and objectives of hospital strategies to concentrate in or discontinue selected services. Second, the contractor assessed whether these strategies were in direct response to variations in the DRG prices or other factors influencing hospital management. Third, it examined the use of product line management and service costing in hospitals' responses to DRG price variations. (8/88)

E-89-01: Urban and Rural Cost Differences: Literature Synthesis and Review (SysteMetrics/McGraw-Hill, Inc.)

The reasons for differences in urban and rural hospitals' costs per case are synthesized from current research in this report. Specifically, the basis for the lower costs of rural hospitals compared with urban hospitals is explored, and further research suggested. (3/89)

E-89-02: Treatment of Certain Hospital Labor Expenses in the PPS Market Basket (SysteMetrics/McGraw-Hill, Inc.)

This report examines certain hospital labor expenses not directly measured by the PPS market basket (contract labor, employee bonuses, recruitment costs, employee benefits, overtime and part-time employment, and changes in employee skill mix).

The project examines how these costs are currently measured in the market basket and changes in these expenses between 1985 and 1988. Estimates were made of the effect these labor expenses would have on market basket increases if the expenses were directly measured in the market basket wage component. The calculations of the Average Hourly Earnings for Non-Supervisory Hospital Workers and the Employment Cost Index for Hospitals are also described in the study. (2/89)

E-90-01: The Relationship Between Declining Use of Rural Hospitals and Access to Inpatient Services for Medicare Beneficiaries in Rural Areas (Codman Research Group, Inc.)

This study examines hospital utilization patterns for Medicare beneficiaries living in defined rural and urban hospital market areas of five states—Alabama, California, Illinois, Montana, and Texas—from 1984 to 1986. The study examines Medicare beneficiary care according to the market area where the beneficiary lives. Cases are divided into eight DRG groups to examine whether access is impaired for some services and not others. The study also examines how these changes in utilization affect admissions and market share of rural and urban hospitals. (1/90)

E-90-02: Alternative Hospital Market Area Definitions (SysteMetrics/McGraw-Hill, Inc.)

This report examines alternative methods for defining hospital market areas through an extensive literature search and contact with experts in the field. The study reviews the role market areas play in PPS. It also reviews numerous alternatives that have been used for defining market areas, exploring options that have not been used for hospitals. Finally, the study provides an evaluation of the alternative methodologies and their potential applicability to PPS for defining hospital labor and product markets. (3/90)

E-90-04: The Dynamics of Hospital Services Changing Patterns in the Services Provided by Hospitals from 1980 to 1987 (Kirsten Iversen)

The level of services and facilities provided by hospitals is dynamic, changing over time and across settings. This analysis describes patterns in the

changing levels of services provided by different groups of hospitals from 1980 to 1987. (3/90)

E-90-05: Methodology for Measuring Case-Mix Change: How Much Change in the Case Mix Is DRG Creep? (The RAND Corporation)

ProPAC assisted the Health Care Financing Administration in a medical record reabstraction study. This study develops a method to distinguish case-mix increases caused by changes in coding practices from changes in treatment patterns and patient mix. It also provides information for developing and refining alternative ongoing data collection methods to monitor case-mix change over time. The Commission helped fund this project and provided support in designing, implementing, and monitoring the study. (4/90)

E-90-07: How Services and Costs Vary by Day of Stay for Medicare Hospital Stays (The RAND Corporation)

This study describes how the cost of services provided during Medicare hospital stays varies throughout the stay. It also examines how patterns of daily costs vary with clinical characteristics, hospital characteristics, and the types of services provided. The study was based on data on the daily services billed to Medicare patients between May 1987 and April 1988 from a sample of 105 hospitals, and was the first time such data had been used in this way. (3/90)

E-90-08: Comparative Analysis of Annual Survey and Medicare Cost Report Margin Data (American Hospital Association)

This study presents the results of a comparative analysis of total hospital margin data derived from a matched sample of Medicare Cost Reports and corresponding American Hospital Association (AHA) annual surveys. Initially, the national average Medicare Cost Report margin was significantly higher than the corresponding annual survey margin. After editing, however, the cost report margin was found to be slightly lower than the AHA figure. A telephone survey was used to investigate the reasons for the cost report/AHA discrepancies. The study analyzes the discrepancies by type of hospital and categorizes the reasons they occur. The study concludes that properly edited cost report income statement data are usable in research applications. Only one

source of bias was documented as significantly affecting calculation of average total margins by hospital group. This was the failure of some public hospitals to report government subsidies as revenue on their Medicare Cost Reports. (9/90)

E-90-09: Hospital Cost Variations Under PPS (Center for Health Policy Studies, Georgetown University)

This study explores the impact of PPS and other factors in accounting for variations in total costs among hospitals during the 1980s. The goal was to understand the extent to which PPS has affected hospital costs, and the mechanisms that have produced those effects. The impact of PPS was isolated by analyzing a time-series of cost data for a sample of hospitals, while controlling for the effects of other factors, such as input prices, mix of outputs, volume of outputs, local competition, and health insurance coverage. The study also focuses on the roles of staffing, service mix, patient volume, and financial pressure to identify the mechanisms that have operated to produce PPS effects. These analyses were conducted separately for all sample hospitals and for important subgroups of the hospital industry, including urban and rural hospitals. (9/90)

E-91-01: Classification Systems for PPS-Excluded and Non-PPS Providers (Project HOPE)

This study provides an overview and evaluation of systems that measure the case mix or resource complexity of patients treated in hospitals excluded from Medicare's PPS or patients treated by non-PPS providers. PPS-excluded hospitals include psychiatric and rehabilitation hospitals and distinct-part units as well as children's, long-term, and cancer hospitals. Non-PPS providers include home health agencies and skilled nursing facilities. The report identifies and describes available research on patient classification systems, case-mix measurement systems, and payment systems for each type of provider. Each system is evaluated using a set of criteria related to patient classification such as administrative feasibility, ability to explain variations in resource use, and clinical validity. Other criteria are applied to the evaluation of payment systems. Among the criteria used are administrative feasibility, equity of the system, and system effectiveness. (1/91)

E-91-02: Study of Health Care Access in Counties Where the Only Hospital Closed (Abt Associates, Inc.)

This report describes a study of access to health services in 22 rural counties where the only hospital closed between 1987 and 1989. These counties are compared with a similar group of counties that did not have a hospital between 1980 and 1989. Access to health care services is evaluated on two dimensions. First, distances and travel times (from the population center of each county) to the nearest hospitals in contiguous counties are identified, and second, the types and numbers of health care providers (facilities and practitioners) in each of the counties are noted. This was accomplished using telephone surveys of county health department personnel and analysis of the Area Resource File. (5/91)

E-91-03: Utilization of Inpatient Hospital Services by Rural Medicare Beneficiaries (Codman Research Group, Inc.)

This study updates a previous analysis (E-90-01) on inpatient hospital utilization for Medicare beneficiaries living in rural and urban market areas of five states: Alabama, California, Illinois, Montana, and Texas. The analysis expands on the earlier study by looking at utilization patterns for rural beneficiaries using refined DRG case-type groupings and by separately examining utilization patterns for younger and older Medicare beneficiaries. The findings from the analysis are consistent with the earlier study, in that access to inpatient hospital services does not appear too constrained for rural Medicare beneficiaries. The study, however, raised concerns about access to ambulatory care in these communities. (5/91)

E-91-04: Volume Adjustments Used in State Medicaid Programs and Rate Setting Systems (Abt Associates, Inc.)

This report presents information about volume adjustments used to adjust payments to hospitals by state Medicaid programs. The contractor surveyed states to determine the number that use a volume adjustment, how the adjustment is calculated, eligibility requirements, whether there are upper and lower thresholds for the adjustment, and the formula used to calculate the adjustment. The contractor also laid out a theoretical framework for considering

volume adjustments, and outlined the relationships between policy goals and characteristics of these adjustments. (7/91)

E-91-05: Medicaid Payment Methodologies for Inpatient Hospital Services (Abt Associates, Inc.)

This report describes state Medicaid inpatient hospital payment methodologies in effect as of July 1, 1991. The information was collected through telephone interviews with knowledgeable staff at state Medicaid offices, rate setting commissions, and hospital associations. The survey attempted to identify, describe, and document key concepts used to develop Medicaid payment systems for inpatient hospital services. (8/91)

E-91-06: An Evaluation of Winners and Losers Under Medicare's Prospective Payment System: A Synthesis of the Literature (Lewin/ICF)

This report summarizes the academic and popular literature on (1) hospital characteristics affecting hospital financial performance under Medicare; (2) the design features that affect winning and losing, and how hospitals responded to the incentives of PPS; and (3) the environmental and community characteristics of a hospital's local market that affect hospital financial performance. In addition, it outlines some of the perceived gaps in the literature and includes an extensive bibliography. (10/91)

E-92-01: Certification Requirements for Nursing Homes (Abt Associates, Inc.)

This report presents descriptive information on current Medicaid certification and state licensure requirements for nursing homes. It focuses on those requirements that are expected to impose significant costs on facilities and result in cost variations across states. (3/92)

E-92-02: An Evaluation of Winners and Losers Under Medicare's Prospective Payment System: Final Report (Lewin/ICF)

This report summarizes the findings of a series of case studies conducted by Lewin/ICF examining why, controlling for similar hospital characteristics, some hospitals do well under PPS while others do not. Factors examined include hospital behavior, such as successful management strategies; hospitals'

responses to PPS; and broader environmental factors that shape hospital performance. The degree to which performance is within a hospital's control is discussed. Individual hospital descriptions are not provided. Rather, the report integrates site visit findings and synthesizes the similarities and differences between successful and unsuccessful hospitals. (5/92)

E-92-03: Report on Quality Assurance in Non-PPS Settings (Abt Associates, Inc.)

This study describes mechanisms used to ensure and monitor quality in settings in which Medicare services are reimbursed. Among these are skilled nursing facilities, home health agencies, and hospitals not paid under PPS (psychiatric hospitals and rehabilitation hospitals). The study also looks at quality assurance in selected outpatient facilities, including ambulatory surgical centers, hospital outpatient departments, ambulatory care centers, cardiac catheterization laboratories, freestanding clinical laboratories, dialysis facilities, diagnostic imaging centers, lithotripsy centers, and comprehensive outpatient rehabilitation facilities. Quality assurance mechanisms including certification, accreditation and monitoring by Federal, state, and voluntary organizations are described. Quality indicators are classified by structure, process, or outcome. (8/92)

E-92-04: Within DRG Case Complexity Change in Fiscal Year 1990 (SysteMetrics/McGraw-Hill, Inc.)

ProPAC annually recommends to the Congress an update factor for increasing the standardized payment amounts under PPS. This update factor reflects changes in the cost of providing services, including changes in the cost of hospital inputs; the effects of scientific and technological advances; productivity increases; and changes in the mix of patients that hospitals treat. The distribution of cases across DRGs is captured by the Medicare case-mix index, which directly affects the payment that hospitals receive for each case. This study measures the change in the distribution of cases by complexity level within DRGs. The study uses Medicare data for fiscal years 1988 through 1990 to develop estimates of within-DRG case complexity change and examines changes in coding of secondary diagnoses, both by overall and by hospital group. (4/92)

E-93-01: Identifying Changes in the Factors of Production for Dialysis Services (Project HOPE)

This report describes an historical cost study of the factors of production for outpatient hemodialysis and peritoneal dialysis services. The study examines how the use or cost of inputs changed between 1983 and 1991, and estimates the incremental or decremental impact that the change in each input has on the cost per dialysis treatment. The study focuses on the incremental effects of scientific and technological advances in the dialysis industry and ensuing productivity improvements. (3/93)

E-93-02: Within DRG Case Complexity Change, 1991 (SysteMetrics, Inc.)

This study measures the change in within-DRG case complexity from 1989 to 1990 and from 1990 to 1991. It also examines changes in the number of secondary diagnoses and complications and comorbidities from 1989 to 1991. This information is used for ProPAC's within-DRG case-complexity adjustment. The within-DRG case-complexity adjustment is designed to capture increases in patient complexity that are not measured by the DRGs. It is part of the case-mix adjustment in ProPAC's annual PPS operating and capital update recommendation to the Congress. The case-mix adjustment allows hospital payments to increase for real case-mix change, while removing payment increases that are due to changes in medical record documentation or coding practices. (2/93)

E-93-03: Exploring the Growth of Hospital Outpatient Surgeries (Abt Associates, Inc.)

This report identifies and assesses the principal factors that contributed to the growth observed between 1988 and 1990 in the use of five groups of procedures performed in the hospital outpatient department. The five groups selected were knee arthroscopy, YAG laser, lithotripsy, sigmoidoscopy and colonoscopy, and breast biopsies. These families of procedures were selected because as a group they represented varying levels of complexity, exemplified a variety of clinical problems, were in the top 50 most frequently performed ASC-approved procedures, and had a high growth rate between 1988-90. The factors affecting increased procedure volume were physician practice patterns and treatment approaches, technology requirements, the capacity of physicians and hospitals to

perform the procedure, shifts in setting in which the procedure is performed, and reimbursement practices. (3/93)

E-93-04: Analysis of the Effect of the Economic Stabilization Program (Abt Associates, Inc.)

This report describes the effect of the economic stabilization program (1971-1974) on health care prices and expenditures. Previous studies of the program are reviewed and compared. Additionally, descriptive data on health care expenditures by type of service and program, health care prices, and hospital revenues and expenditures are displayed. (5/93)

E-93-05: State Regulations and Policies that Affect the Provision of Post-Acute Care (Abt Associates, Inc.)

This report presents descriptive information about state regulations and policies that affect the staffing requirements, services provided, and patient mix of Medicare-certified skilled nursing facilities and home health agencies. (5/93)

E-93-06: Development of Hospital Efficiency Measures (Jenifer Ehreth, Ph.D.)

This report evaluates several measures of how efficiently hospitals use their capital assets and compares asset efficiency and hospital financial performance across types of hospitals. Descriptive statistics and factor analysis are used to assess the reliability and validity of several measures over a three-year period. Three measures—the current ratio, the long-term debt to net fixed assets ratio, and an asset efficiency measure using data envelopment analysis techniques—are evaluated in more detail because they appear promising for analyzing the impact of payment policies on asset efficiency. (8/93)

E-94-01: Within DRG Case Complexity Change, 1992 (SysteMetrics, Inc.)

This study measures the change in within-DRG case complexity from 1990 to 1991 and from 1991 to 1992. It also examines changes in the number of secondary diagnoses, complications and comorbidities from 1990 to 1992. ProPAC uses this information to estimate the annual amount of real case mix change within DRGs, which is not measured by the case mix index (CMI). Unlike previous studies of within-DRG case complexity change, this study investigates the long run trend

for within-DRG case complexity change between 1985 and 1992, by hospital group. Potential explanations for the observed long run trend are discussed. (3/94)

E-94-02: The Incremental Impact of Scientific and Technological Advances on Operating Costs in PPS Hospitals and PPS-Excluded Facilities (FY 1995) (Abt Associates, Inc.)

This report provides supportive material for one component of ProPAC's update recommendations to the Congress: the allowance for scientific and technological advances (S&TA). It details the revised approach to estimating incremental costs attributable to technological change projected for fiscal year 1995. Two S&TA estimates were developed: one for changes in operating costs incurred by PPS hospitals and another for facilities excluded from PPS that are subject to the payment system established in the Tax Equity and Fiscal Responsibility Act of 1982. (1/94)

E-94-03: The Incremental Impact of Scientific and Technological Advances on Capital Costs in PPS Hospitals (FY 1995) (Abt Associates, Inc.)

This report provides supportive material for one component of ProPAC's PPS capital update recommendation to the Congress: the allowance for scientific and technological advances. It details the revised approach to estimating incremental capital costs attributable to technological change projected for fiscal year 1995. (1/94)

E-94-04: The Incremental Impact of Scientific and Technological Advances on Cost Increases in Dialysis Facilities (FY 1995) (Abt Associates, Inc.)

This report provides supportive material for one component of ProPAC's composite rate update recommendation to the Congress: the allowance for scientific and technological advances. It details the revised approach to estimating incremental costs attributable to technological change projected for fiscal year 1995. (1/94)

E-94-05: Discussion Report: Assessing the Impact of Cost-Decreasing Technological Change on Medicare Inpatient Costs (Abt Associates, Inc.)

To support its PPS payment update recommendations submitted to the Congress each year,

ProPAC uses a technology-specific methodology to assess changes in the cost-increasing effects of emerging technologies. This report provides discussion of the feasibility of applying this methodology to an analysis of the financial impact of cost-decreasing technologies used in the care provided to Medicare beneficiaries in the inpatient setting. (7/94)

E-94-06: Discussion Report: Assessing the Cost Impact of Technological Change on Medicare and Non-Medicare Populations Across Settings (Abt Associates, Inc.)

To support its PPS payment update recommendations submitted to the Congress each year, ProPAC uses a technology-specific methodology to assess changes in the cost-increasing effects of emerging technologies. The methodology is specific to the technologies used in the care provided to Medicare beneficiaries in the inpatient setting. This report provides discussion of the feasibility of applying this methodology to an analysis that would consider changes in the cost of technologies used in the care of Medicare and non-Medicare beneficiaries across settings: in the inpatient setting as well as other sites of care, including nursing homes, outpatient departments, and home health agencies. (7/94)

E-94-07: Medicaid Reimbursement Methodologies and Payment Rates for Home Health Agencies (Abt Associates, Inc.)

This study presents survey results on state Medicaid programs' reimbursement methodologies and payment rates for home health care services. Information is presented in table format for each service (skilled nursing; physical, speech, and occupational therapies; medical social services; and home health aides). Each table includes information on the following items: payment rates; rate-setting methodologies; whether the rate is agency-specific, class-based, or flat; cost components that are treated separately in the payment process; and payment update factors. (1/94)

E-94-08: Quality-Oriented State Licensing Requirements for Non-PPS Facilities (Abt Associates, Inc.)

This two-volume study presents survey results on state licensing requirements for 15 long-term care,

home health, and ambulatory care providers. Information is presented on state standards for organizational structure and administration, personnel, service provision, medical documentation, internal quality assurance processes, minimum access and transfer affiliations, equipment, and certificate of need. Licensure requirements that differ from Medicare certification are emphasized. (7/94)

E-95-01: A Comparison of Cost Definitions (Project HOPE)

This report provides a comparison of cost definitions between Medicare principles of reimbursement and generally accepted accounting principles. It documents cost items pertaining to acute care hospital services and outpatient dialysis services that are nonallowable in accordance with Medicare payment policy. In addition, the report discusses providers' contests of Medicare's determination of allowable costs, where applicable, and the results of those cases. (2/95)

E-95-02: Medicaid Managed Care Program Access Requirements (Project HOPE)

This report examines seven states' strategies for ensuring access to health services for Medicaid-eligible people who are enrolled in managed care plans. It summarizes approaches states are using to ensure that enrollees receive medically appropriate services without facing geographic, cultural, or linguistic barriers to care. This report presents information gathered from both state Medicaid agencies and Medicaid managed care contractors. (4/95)

E-96-01: The Incremental Impact of Scientific and Technological Advances on Cost Increases in Dialysis Facilities (FY 1997) (Abt Associates, Inc.)

Each year, ProPAC recommends to the Congress an update to the composite rate for dialysis services. The Commission's update framework includes an allowance for the incremental impact of scientific and technological advances. This report describes ProPAC's estimate of the increase in operating and capital costs that will result from the diffusion of new and emerging dialysis-related technologies in fiscal year 1997. (1/96)

Pending

Quality of Dialysis in the United States (Project HOPE)

This report is a critical review of the current literature relevant to the quality of outpatient dialysis services. It addresses issues related to the epidemiology and treatment of end-stage renal disease, defining and measuring quality of care, assessing patient outcomes, and comparing mortality rates between the United States and other countries. (Forthcoming)

Hospital-Physician Relations: A Multivariate Analysis of Hospital Financial Performance (Project HOPE).

This report will examine the association between hospital-physician relations and hospital financial performance. Data from ProPAC's Hospital-Physician Relations study (I-95-02) were combined with secondary data on hospital market characteristics and hospital financial performance and analyzed using both univariate and multivariate techniques. (Forthcoming)

INTRAMURAL TECHNICAL REPORT SERIES

I-88-02: Recalibration Analysis Comparing Charge-Based and Cost-Based DRG Weights

ProPAC analyzed the two methods of recalibrating the DRG relative weights, using charges only (charge-based) and using charges that are adjusted by costs (cost-based). This report provides a detailed description of the data, methods, and results of ProPAC's comparisons. (3/88)

I-89-03: Review of Medicare Cost Report Data for Policy Analysis

This report summarizes the Commission's work on the use of the Medicare Cost Report data for decision making. The major activity the Commission initiated to identify improvements in the use of existing cost data for policy analysis was to convene a panel to discuss the strengths and weaknesses of the Medicare Cost Report. The report also summarizes ProPAC monitoring of HCFA's three-year demonstration assessing the costs and benefits of adding to the cost report financial and utilization information regarding other payers. (3/89)

I-89-04: Payment Adjustments—Indirect Teaching and Disproportionate Share Hospitals

ProPAC analyzed the effect of teaching effort on Medicare costs. The objectives of the analysis were to estimate the relationship between teaching effort and Medicare cost per case using the most recent Medicare Cost Report data available. ProPAC also examined the overlap between the indirect medical education and the disproportionate share payment adjustments and evaluated the financial impact of revising the indirect medical education adjustment. The report describes the methods and results of the analysis. (7/89)

I-90-01: Medicare-Dependent Hospitals Under PPS

The Omnibus Budget Reconciliation Act of 1989 required the Commission to study the appropriateness of making a Medicare payment adjustment to hospitals that treat a high proportion of Medicare discharges. Information on this topic was also included in ProPAC's June 1990 report, *Medicare Prospective Payment and the American Health Care System*. (6/90)

I-90-02: Adjusting the Area Wage Index for Occupational Mix

Currently, the area wage index does not account for geographic differences in occupational mix. ProPAC studied the effect of adjusting the area wage index for occupational mix and the relationship of occupational mix to case mix. This report describes the methods and results of the analysis. The results include metropolitan statistical area, regional, and urban/rural estimates of the impact. The report also calculates how payments would be affected by adjusting the wage index for occupational mix. (8/90)

I-90-04: Financial Status of High Case Mix Hospitals

The Omnibus Budget Reconciliation Act of 1989 required the Commission to study the financial status of high case mix hospitals with special attention devoted to capital investment. Information on this topic was included in ProPAC's June 1990 report, *Medicare Prospective Payment and the American Health Care System*. (9/90)

I-91-01: Hospital Closures: 1985-1988

This report contains descriptive statistics on hospitals that closed between 1985 and 1988. Data are from the American Hospital Association Annual Survey of Hospitals, Medicare Cost Reports, and the Area Resource File. Rural and urban hospitals that closed are analyzed separately and compared with open rural and urban hospitals having fewer than 200 beds. (1/91)

I-91-02: The Role of Profitability and Community Characteristics in Hospital Closures, an Urban and Rural Analysis

This study investigates hospital closures that occurred from 1985 through 1988. The analysis focuses on the relationship between profitability and closure. Further, the analysis evaluates the impact on profitability of characteristics related to the hospital's mission and standing in the community. In addition, the analysis is extended by examining the factors that influence profitability and its components: revenue per case, cost per case, and total cases. This report provides a detailed description of the data, methods, and results of the study. (2/91)

I-91-03: Improving the Area Wage Index: The Area Wage Index and the Mix of Occupations Across Areas

Currently, the area wage index incorporates differences in the price of labor, as well as the mix of occupations across areas. This report presents the results of ProPAC's study on the effect of adjusting the area wage index for occupational mix. The results are presented separately for metropolitan statistical areas and rural areas. The study is based on Uniform Reporting System data collected from California hospitals. The report also describes the method used in California to collect data by occupational category. (7/91)

I-91-04: The Trend and Distribution of Hospital Uncompensated Care Costs, 1980-1989

This report presents the results of an analysis of uncompensated care costs for both PPS and PPS-excluded hospitals. Uncompensated care for this study is defined as the sum of charity care and bad debts, and uncompensated care costs are measured both with and without an offset for subsidies received from state and local governments. The

study is based on data from the American Hospital Association Annual Survey of Hospitals over the period 1980 to 1989. Both the trend and distribution of uncompensated care costs are measured by hospital group. In addition, the relationship between uncompensated care costs and indirect medical education and disproportionate share payments under Medicare is examined. (10/91)

I-92-01: Winners and Losers Under PPS

Although the aggregate margin of hospitals under PPS has declined, some hospitals continue to perform well. In this report, ProPAC analyzes the characteristics of hospitals with consistently high and consistently low margins under PPS in 1986, 1987, and 1988. The characteristics are broken into three groups: payment adjustments, factors within the hospital's control, and factors outside of the hospital's control. The focus of the study is to determine the relative role of these factors in performance under PPS. This report provides a detailed description of the data, methods, and results of the study. (6/92)

I-92-02: The Effect of the OBRA 1989 Payment Provisions for Small Rural Medicare-Dependent Hospitals

In 1989 and 1990, ProPAC analyzed the financial status of hospitals with high Medicare shares. The ProPAC analysis, described in *Medicare-Dependent Hospitals Under PPS* (TRS I-90-01), indicated that the classification of hospitals into groups based on Medicare dependence is arbitrary and inconsistent over time. Further, although hospitals with high Medicare shares tend to perform more poorly under PPS, this poor performance appears to be related to characteristics other than Medicare share, notably low occupancy rates and long average lengths of stay. Based on these findings, the Commission recommended that no payment adjustment be made for Medicare-dependent hospitals. In the Omnibus Budget Reconciliation Act (OBRA) of 1989, Congress provided special treatment under PPS for small rural Medicare-dependent hospitals for three years (cost reporting periods beginning on or after April 1, 1990, and ending on or before March 31, 1993). This provision expired in 1993. However, the Congress extended it through fiscal year 1994. This report describes an analysis of the financial performance of small rural Medicare-dependent hospitals as defined in OBRA 1989 and

the impact of the special provision on Medicare payment of these hospitals. (7/92)

I-93-01: The Accuracy of Cost Measures Derived from Medicare Cost Report Data

This report summarizes the findings and policy implications of a study conducted by the Center for Health Policy Studies. The primary objective of the study was to assess the accuracy of the hospital-level and DRG-level cost measures that can be constructed using Medicare Cost Report data. The first part of the study tested the impact of potential refinements in the Medicare Cost Report cost finding approach, such as using a standard cost center configuration or a multiple allocation technique. These types of changes were found to have relatively little impact. The second part compared values from advanced hospital cost accounting systems with values from the cost reports of the same hospitals. Substantial differences were documented for total Medicare costs, routine and ancillary costs, and average cost per case by DRG. (3/93)

I-95-01: The Relationship Between Hospital Costs and Payments by Source of Revenue, 1980-1991

This report presents an analysis of community hospital losses and gains by source of revenue, including Medicare, Medicaid, uncompensated care, private payers, and non-patient revenue. The data for the analysis are from the American Hospital Association Annual Survey of Hospitals. The report includes trend data on payments, costs, and charges. Data from 1991 are used to analyze the distribution of gains and losses for the different revenue sources, the relationship between these losses and hospital margins, and state-by-state differences. The report also compares the characteristics of hospitals that are and are not able to recover significant losses from uncompensated care, Medicaid, and Medicare through cost shifting. (10/95)

I-95-02: Hospital-Physician Relations: A National Survey of Hospital Chief Executive Officers and Chiefs of Medical Staffs

In an effort to identify factors that affect the financial performance of hospitals, ProPAC has undertaken a study of the financial effects of different organizational structures and mechanisms hospitals

use to influence physician behavior. In the first phase of the project, ProPAC sponsored a national survey of hospital chief executive officers (CEOs) and chiefs of medical staff (CMSs) to evaluate the various aspects of hospital-physician relations. The survey explored the organization of hospital services; physician recruitment, retention, and evaluation; physician roles and responsibilities within hospitals; and hospital-physician financial arrangements. It also sought to ascertain how CEOs and CMSs perceived the respective roles they play and the influence of hospital management and physician staff within the hospital environment. The report describes survey methods and results, including differences in approaches to hospital-physician relations employed by different types of hospitals. The next phase, a multivariate analysis, will link hospital financial data with data from the national survey. (11/95)

I-95-03: Medicare Transfer Payment Policy

This report presents the results of an analysis of Medicare's payment for transfer cases. Currently, the transferring hospital is paid a uniform per diem payment up to the full DRG amount. The receiving hospital is paid the full DRG payment if it is the final discharging hospital. The analysis examines the relationship between payments and costs for these cases. In addition, it examines the characteristics of hospitals and cases involved in a transfer sequence. The study also includes information on trends in transfer rates since 1984. (6/95)

I-95-04: A Review of ProPAC's Allowances for Scientific and Technological Advances

This report describes the study ProPAC conducted to support the Commission's decisions regarding the allowances for scientific and technological advances (S&TA) for the PPS operating and capital payment update recommendations for fiscal year 1996. The Commission used a qualitative approach to assess S&TA costs, evaluating more generally whether any changes in technology costs have altered the trend established in previous years. This report reviews previous allowances, the technologies assessed, advances that may affect Medicare costs, and, finally, the Commission's decisions for the two PPS S&TA allowances for fiscal year 1996. It also discusses how ProPAC's technology-specific methodology differs from other approaches to technology costing, and evaluates how well the

methodology captures the information intended by the S&TA allowance. (4/95)

I-95-05: Hospital Costs and Payments by Revenue Source: The Impact of Medicaid Payment Increases in 1992

This report supplements ProPAC's recent report on hospital losses and gains by source of revenue (TRS I-95-01). Like the first report, this one analyzes the trend in payments relative to costs by payer, as well as differences by type of hospital and by state. The focus throughout this report, however, is the impact of substantial increases in revenue received by many hospitals in 1992 from Medicaid disproportionate share payments. This includes the impact on overall Medicaid payments and on the pattern of cost shifting to the private sector. (10/95)

Joint Report to the Congress on Medicare Managed Care

The Prospective Payment Assessment Commission and the Physician Payment Review Commission prepared this joint report on the role of managed care within the Medicare program. It describes program policies and analyzes options concerning beneficiary enrollment, plan participation, payment policy, access and quality, and data constraints. (10/95)

Pending

Medicare Per Capita Expenditures and Costs

This report will present a descriptive analysis of the variation in 1991 per capita expenditures for elderly beneficiaries by state and between the rural and urban areas of each state. Four per capita measures are being developed: (1) Medicare spending, (2) Medicare payments standardized to the national level (which will isolate geographic differences in utilization), (3) the provider production costs associated with Medicare spending, and (4) production costs adjusted for geographic price differences. All four of these measures will be broken down by setting, with physician services attributed to the setting in which they were provided. Geographic comparison will also be enhanced in the second and fourth measures by controlling for age and sex differences and by adding an estimated value for care provided to the elderly in military and Department of Veterans Affairs hospitals. (Forthcoming)

CONGRESSIONALLY MANDATED REPORTS

C-88-01: An Evaluation of the Department of HHS Report to Congress on Studies of Urban-Rural and Related Geographical Adjustments in the Medicare PPS

The Omnibus Budget Reconciliation Act of 1987 required ProPAC to report to the Congress on its evaluation of the Secretary's study on the feasibility and impact of eliminating or phasing out separate urban and rural payment rates. The report is organized into four major sections: background and definition of issues, summary of the Secretary's study methods and findings, ProPAC's evaluation of the Secretary's study, and future direction of Commission activities. (6/88)

C-88-02: Linking Medicare Capital Payments to Hospital Occupancy Rates

The Omnibus Budget Reconciliation Act of 1987 required ProPAC to report to the Congress on the suitability and feasibility of linking Medicare capital payments to hospital occupancy rates. This was addressed by reviewing current Medicare capital payment principles, examining historical trends in capital costs and occupancy rates, and analyzing the relationship between capital costs and occupancy. (4/88)

C-88-03: Outlier Payment Alternatives for Burn Cases

The Omnibus Budget Reconciliation Act of 1987 required ProPAC to study alternative payment methods for burn outlier cases under the prospective payment system. In this report, the Commission examines costs and PPS payments for all burn cases, as well as those for outlier cases only. Differences between payments and costs for burn hospitals and units and other PPS hospitals are examined. (7/88)

C-88-04: The Views of the Prospective Payment Assessment Commission on Developing Medicare Payment for Hospital Outpatient Surgery

The Omnibus Budget Reconciliation Act of 1987 required the Secretary of Health and Human Services to solicit ProPAC's views in developing outpatient payment systems and to include these views

in a series of reports to Congress. This report focuses on the facility component of payment for surgeries performed in hospital outpatient settings. (8/88)

C-88-05: Separate PPS Payment Rates for Hospitals in Large Urban Areas and Other Urban Areas

The Omnibus Budget Reconciliation Act of 1987 required ProPAC to "evaluate the desirability of maintaining separate DRG prospective payment rates for hospitals located in large urban areas...and in other urban areas." The report first describes how PPS currently treats hospitals in different sized urban areas. Descriptive information comparing hospitals in these areas is then presented. This is followed by a discussion of the PPS policy implication of variation in costs and margins by metropolitan statistical area size. (12/88)

C-89-01: Medicare Payment for Hospital Outpatient Surgery: The Views of the Prospective Payment Assessment Commission

The Omnibus Budget Reconciliation Act of 1987 required the Secretary of Health and Human Services to solicit the Commission's views on prospective payment for hospital outpatient surgery. This report contains ProPAC's recommendations and related rationale on such payment policy beginning in fiscal year 1990. It also presents background information used by the Commission in its deliberations, including the findings of ProPAC's analysis of hospital outpatient surgery costs. (4/89)

C-89-02: Payment Rates for Hospitals Redesignated from Rural to Urban: Analysis and Recommendations

The Technical and Miscellaneous Revenue Act of 1988 required ProPAC to study and report to Congress on the appropriate PPS payment for hospitals redesignated as urban in the Omnibus Budget Reconciliation Act of 1987. This study evaluates the payment policy and the treatment of wage and wage-related costs in computing area hospital wage indexes. The financial impact of various policy options on both the redesignated hospitals and on other hospitals located in the affected urban and rural areas is also assessed. (8/89)

C-89-03: Adjustment to the Non-Labor-Related Portion of the Standardized Amounts

The Omnibus Budget Reconciliation Act of 1987 required ProPAC to analyze the feasibility and appropriateness of a geographic adjustment to the non-labor-related portion of the PPS standardized amounts. Price data for non-labor components of the hospital market basket are compiled from available data sources to determine whether non-labor prices vary by geographic area. The report contains this information and the Commission's determination of whether such an adjustment is feasible and appropriate. (8/89)

C-89-04: Adequacy of PPS Payment for Medicare Beneficiaries with Hemophilia

The House Ways and Means Committee asked ProPAC to assess the adequacy of PPS payment for Medicare inpatients with hemophilia. This report studies the population size, trends in the price of the clotting factor, and the financial impact on hospitals for treating these patients. (10/89)

C-90-01: Medicare Payments to Rural Sole Community Hospitals and Small Rural Hospitals

The Omnibus Budget Reconciliation Act of 1989 required the Commission to submit a report to Congress on the feasibility and desirability of using a cost-based reimbursement system for paying small rural hospitals and sole community hospitals. Further, ProPAC was to assess the impact of using alternative market share definitions to determine eligibility for sole community hospital classification, and of accounting for decreases in admissions in determining payments to small rural hospitals or their costs. This report summarizes the Commission's findings. (5/90)

C-90-02: Hospital Outpatient Services Background Report

The Omnibus Budget Reconciliation Act of 1989 required the Commission to submit a report to Congress on several issues related to outpatient payments. This report examines the growth in hospital outpatient services and the revenues generated by outpatient visits. The costs of providing services in hospital outpatient departments are compared to those associated with freestanding centers. Last, outpatient quality assurance and peer review are discussed. (7/90)

Medicare-Dependent Hospitals

The Omnibus Budget Reconciliation Act of 1989 required the Commission to study the appropriateness of making an adjustment to Medicare payments to hospitals that treat a high proportion of Medicare discharges. Information on this topic was included in ProPAC's June 1990 report, *Medicare Prospective Payment and the American Health Care System*. (6/90)

Financial Status of High Case Mix Hospitals

The Omnibus Budget Reconciliation Act of 1989 required the Commission to study the financial status of high case mix hospitals with special attention devoted to capital investment. Information on this topic was included in ProPAC's June 1990 report, *Medicare Prospective Payment and the American Health Care System*. (6/90)

Area Wage Index

The Omnibus Budget Reconciliation Act of 1990 required ProPAC to examine available data from states and other sources measuring earnings and paid hours of employment of hospital workers by occupational category. The impact of variation in occupational mix on the computation of the area wage index is included. Information on this topic was included in ProPAC's March 1991 *Report and Recommendations to the Congress*. (3/91)

Nurse Practitioners and Other Non-Physician Providers

The Senate Committee on Appropriations asked that ProPAC study the use of nurse practitioners and other non-physician providers in settings other than acute care facilities and long-term care institutions. Information on this topic was included in ProPAC's June 1991 report, *Medicare and the American Health Care System*. (6/91)

C-91-01: Medicare's Capital Payment Policy

This report summarizes the Commission's analyses of hospital capital costs and views on Medicare's capital payment policy. ProPAC's objectives for evaluating capital payment, along with supporting data and opinions, are presented. The Commission also comments on the Secretary of Health and Human Services' prospective payment proposal. (5/91)

C-91-02: Medicaid Hospital Payment

The Omnibus Budget Reconciliation Act of 1990 required the Commission to conduct a study of Medicaid hospital payment rates. The study examines the relationship between Medicaid and Medicare payments, and the financial condition of the hospitals receiving Medicaid payments. Special attention is given to hospitals in urban areas that treat large numbers of people eligible for Medicaid and other low-income persons. (10/91)

C-91-03: Rural Hospitals Under Medicare's Prospective Payment System

The Senate Committee on Appropriations requested a report examining the changes made in rural hospital payment policies and their fiscal impacts. The report includes an analysis of the impact of 1991 payment rules on 1984 and 1989 hospital margins and assesses the relative importance of individual policy changes. In addition, ProPAC was asked to study the effect of low volume on overhead costs and payments. The report includes a discussion of the relationship between volume and financial performance, and case mix and performance. The adequacy of national DRG weights for rural hospitals and differences between sole community and other small rural hospitals' characteristics and financial condition are also discussed. Finally, the report includes a profile of services offered by rural hospitals. (10/91)

C-91-04: Passthrough Payments for Hemophilia Inpatients

The Omnibus Budget Reconciliation Act of 1989 required the Commission to submit a report to Congress that contains recommendations on paying for the cost of administering blood clotting factors to inpatients with hemophilia. This report summarizes the Commission's findings. (6/91)

C-92-01: Prospective Payment System for Medicare's Skilled Nursing Facility Payment Reform

The Omnibus Budget Reconciliation Act of 1990 required the Secretary of Health and Human Services to develop a proposal to modify the current system under which skilled nursing facilities receive payment for extended care services under Medicare Part A or a proposal to replace this system with a prospective payment system. The

Commission is required to submit an analysis of and comments on the proposal. This background report describes the Medicare SNF benefit, payment method, and beneficiary utilization. A cost function analysis provides information on variations in costs across facilities. Federal and state regulations affecting facility costs and use of the benefit also are discussed. This report concludes with recommendations concerning the need for a nursing facility wage index and case-mix adjustment in Medicare's payment policy. When the Secretary's report is released, the Commission will submit comments to the Senate Committee on Finance and the House Committee on Ways and Means. (3/92)

C-92-02: Medicare Payment for Hospital Outpatient Services: The Views of the Prospective Payment Assessment Commission

The Omnibus Budget Reconciliation Act of 1990 required the Secretary of Health and Human Services to develop a model system for Medicare payment for hospital outpatient services. The Commission is required to submit an analysis of and comments on the proposal. This background report describes Medicare's outpatient payment policies, which may vary by site of care and type of service. Ambulatory surgery and radiology are used to discuss problems with the current payment policy. The report concludes with nine recommendations for outpatient payment policy reform. When the Secretary's report is released, the Commission will submit its comments. (3/92)

C-92-03: Optional Hospital Payment Rates for Private Payers Based on Medicare's Methods (As specified in H.R. 3626)

This report addresses the development and impact of a system of Medicare-based rates for optional use by private insurers to control the growth in their payments to hospitals. The first part of the report discusses the design decisions that would need to be made, the steps necessary for orderly implementation of the system, and the administrative processes for ongoing operation of the system. The second part presents data on cost shifting in the hospital industry, and then uses these and other data to estimate the savings that would result from using optional rates under several different sets of assumptions. It also includes a discussion of the effects of optional rates on hospitals, private and

government insurers, other providers, and patients. (3/92)

C-92-04: End-Stage Renal Disease Payment Policy

The Omnibus Budget Reconciliation Act of 1990 required the Commission to conduct a study to determine the costs, services, and profits associated with various modalities of dialysis treatments provided to end-stage renal disease patients. This study is the basis for recommendations regarding the method and level of payments for the facility component of dialysis services beginning in fiscal year 1993. The methodology to be used to update payment for subsequent fiscal years is included. As part of its annual March report, starting with fiscal year 1993, ProPAC is required to report its recommendations to Congress on an appropriate payment update factor. (6/92)

C-92-05: Interim Report on Payment Reform for PPS-Excluded Facilities

The Omnibus Budget Reconciliation Act of 1990 required the Secretary of Health and Human Services to develop a proposal to modify the current system under which PPS-excluded hospitals receive payment for the operation and capital-related costs of inpatient hospital services under Part A of the Medicare program. Alternatively, the Secretary could propose a system with payments made on the basis of nationally determined average standardized amounts. Although the Secretary has not submitted her proposal, the Commission prepared this background report. When the Secretary's report is released, the Commission will analyze it and submit comments to the Senate Committee on Finance and the House Committees on Ways and Means, and Energy and Commerce. (10/92)

C-93-01: Global Budgeting: Design and Implementation Issues

In response to a request from the House Committee on Ways and Means, Subcommittee on Health, the Commission examined the implementation of a global budgeting system. ProPAC focused on the system's application to hospitals and other institutional health care services. The report addresses issues involved in the allocation of a national budget among types of health care services, the availability of data to support the system, and the

mechanisms for ensuring that budget targets are met. (7/93)

C-94-01: Analysis of Medicaid Disproportionate Share Payment Adjustments

The Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (P.L. 102-234) required ProPAC to conduct a study of Medicaid disproportionate share payment adjustments. This study examines the feasibility and desirability of establishing maximum and minimum payment adjustments for hospitals deemed disproportionate share hospitals. It also assesses criteria (other than existing ones) that are appropriate for designating disproportionate share hospitals under Section 1923 of the Social Security Act. The report was submitted to the Senate Committee on Finance and the House Committee on Energy and Commerce. (1/94)

C-94-02: Interim Analysis of Payment Reform for Home Health Services

The Omnibus Budget Reconciliation Act of 1990 required the Secretary of Health and Human Services to develop a proposal to modify the current system under which Medicare pays for home health services or a proposal to replace such system with a prospective payment system. The Commission is required to submit an analysis of and comments on the proposal to the Senate Committee on Finance and the House Committee on Ways and Means. This background report describes Medicare's home health benefit, payment method, use, and agency costs and payments. Federal and state regulations affecting access and quality of care also are discussed. When the Secretary's report is released, the Commission will submit comments to the Senate Committee on Finance and the House Committee on Ways and Means. (3/94)

C-95-01: Analysis of the Secretary's Proposal for Medicare Payment for Hospital Outpatient Services

The Omnibus Budget Reconciliation Act of 1990 required the Secretary of Health and Human Services to develop, and the Commission comment on, a model system for Medicare payment for hospital outpatient services. This report describes Medicare's payment policies for outpatient services, documents the increase in outpatient expenditures,

and identifies problems related to the current payment system. The Secretary's proposed reforms are discussed, and three recommendations for the Congress and the Secretary are included. (7/95)

Pending

Analysis of the Secretary's Proposal for Skilled Nursing Facility Payment Reform

The Omnibus Budget Reconciliation Act of 1990 required the Secretary of Health and Human Services to develop a proposal to modify the current system under which skilled nursing facilities receive payment for extended care services under Medicare Part A or a proposal to replace this system with a prospective payment system. The Commission is required to submit an analysis of and comments on the proposal to the Senate Committee on Finance and the House Committees on Ways and Means, and Energy and Commerce. (This report will be issued after the Secretary's proposal becomes available.)

Analysis of the Secretary's Proposal for Payment Reform for PPS-Excluded Facilities

The Omnibus Budget Reconciliation Act of 1990 required the Secretary of Health and Human Services to develop a proposal to modify the current system under which PPS-excluded hospitals receive payment for the operation and capital-related costs of inpatient hospital services under Part A of the Medicare program. Alternatively, the Secretary could propose a system with payments made on the basis of nationally determined average standardized amounts. The Commission is required to submit an analysis of and comments on the Secretary's proposal to the Senate Committee on Finance and the House Committees on Ways and Means, and Energy and Commerce. (This report will be issued after the Secretary's proposal becomes available.)

Analysis of the Secretary's Proposal for Home Health Service Payment Reform

The Omnibus Budget Reconciliation Act of 1990 required the Secretary of Health and Human Services to develop a proposal to modify the current system under which Medicare pays for home health services or a proposal to replace such system with a prospective payment system. The Commission is

required to submit an analysis of and comments on the proposal to the Senate Committee on Finance and the House Committee on Ways and Means. (This report will be issued after the Secretary's proposal becomes available.)

**Analysis of the Secretary's Legislative Proposal
Eliminating Separate Average Standardized
Amounts**

The Omnibus Budget Reconciliation Act of 1989 required the Secretary of Health and Human

Services to prepare a legislative proposal eliminating separate average standardized amounts for hospitals located in large urban, other urban, and rural areas. It also directed ProPAC to submit a report to Congress analyzing this proposal and its impact on hospitals. (This report will be issued after the Secretary's proposal becomes available. It should be noted that in OBRA 1990, Congress mandated the elimination of the separate rural standardized payment amount by fiscal year 1995.)

Appendix B. Biographical Sketches of Commissioners

Stuart H. Altman, Chairman

Stuart H. Altman is the Sol C. Chaikin Professor of National Health Policy at the Florence Heller Graduate School of Social Policy at Brandeis University. An economist whose research interests are primarily in the area of Federal health policy, he has been at Brandeis since 1977. Between 1971 and 1976, Dr. Altman was deputy assistant secretary for planning and evaluation/health at the Department of Health, Education, and Welfare (now the Department of Health and Human Services). From 1973 to 1974, he also served as the deputy director for health of the President's Cost of Living Council, where he was responsible for developing the council's program on health care cost containment. Dr. Altman is a member of the Institute of Medicine of the National Academy of Sciences and a former member of its governing council, and serves on the board of Beth Israel Hospital (Boston). He is a past president of the Association for Health Services Research and a former board member of the Robert Wood Johnson Clinical Scholars Program. He has testified before the Congress on a wide range of health policy issues and has written an array of articles in the field. Dr. Altman received a B.B.A. from the City College of New York, and both an M.A. and a Ph.D. in economics from the University of California, Los Angeles.

Susan S. Bailis

Susan S. Bailis is president and chief operating officer of The A•D•S Group, which specializes in long-term care and senior living. From 1983 to 1985, Ms. Bailis was associate director of New England Medical Center, where she managed the hospital's entry into the long-term care field. Earlier, she was director of social services at the medical center. Ms. Bailis has held a number of academic appointments, most recently as assistant professor of psychiatry at Tufts University School of Medicine. She serves on the boards of several hospitals and has held leadership positions in many local and national professional and community organizations. These include the executive committee of the American Health Care Association, president of the

Massachusetts Federation of Nursing Homes, the board of the Alzheimer's Disease and Related Disorders Association, the board of Simmons College, the board of overseers of the Florence Heller School at Brandeis University, secretary of the National Association of Social Workers, and president-elect of the Society for Hospital Social Work Directors of the American Hospital Association. She is a member of the Business Leadership Forum and Women's Leadership Forum of the Democratic National Committee. She also served as a member of the Massachusetts Medicaid State Advisory Board. Ms. Bailis has published and lectured widely on health care and social welfare policy. She received a B.A. from Brandeis University and an M.S.W. from Simmons College School of Social Work.

James D. Bernstein

James D. Bernstein is director of the North Carolina Office of Rural Health and Resources Development, which has established 65 community-based health centers and recruited more than 1,100 providers to the state since 1973. Previously, Mr. Bernstein administered a 40-bed hospital and eight health centers for the Indian Health Service. He has held a variety of professional positions, including chairman of the Rural Health Care Advisory Panel of the Office of Technology Assessment. He currently is national program director for the Robert Wood Johnson Foundation initiative, Practice Sites: State Primary Care Development Strategies. Mr. Bernstein received a B.A. from the Johns Hopkins University and an M.H.A. from the University of Michigan.

Clay D. Edmands

Clay D. Edmands is president of Salina Regional Health Center in Salina, Kansas, an acute care rural referral center. His prior experience includes several years with the Fairview Hospital System in Minneapolis, Minnesota, where he held various positions, among them administrator for development and operations of regional health management and supportive services. Mr. Edmands was on the board of the Kansas Hospital Association from 1980 to

1992, serving as chairman, treasurer, and member of the executive committee. In addition to two terms on a regional policy advisory board of the American Hospital Association, Mr. Edmands has been board president of the Health Systems Agency of Western Kansas. Other community involvements include the Salina health education board and Voluntary Hospitals of America. Currently a preceptor for the University of Kansas program in health care administration and chair of the university's health care services advisory board, Mr. Edmands formerly was a faculty preceptor for the University of Minnesota independent study program in hospital administration. He holds a B.S. in business administration from the University of Kansas and an M.H.A. from the University of Minnesota.

Spencer Johnson

Spencer Johnson has been president of the Michigan Health and Hospitals Association since 1985. Previously, he was executive vice president of the Hospital Association of New York State. Mr. Johnson's prior experience includes staff positions on the U.S. Senate Committee on Human Resources and in the U.S. House of Representatives. He was associate director of the Domestic Council for Health, Social Security, and Income Assistance from 1976 to 1977, where he was responsible for policy planning and development for President Gerald Ford. Mr. Johnson has been a member of the American Hospital Association's State Issues Forum and Council on Allied and Government Relations. He has served on various boards, including those of the Albany Medical College, Washington Hospital Center, the Alpha Center for Health Planning, and the Genesee Regional Health Planning Council. Mr. Johnson received a B.A. in journalism from St. Bonaventure University and an M.P.A. in health policy and planning from Cornell University.

Clark E. Kerr

Clark E. Kerr is president of ConsumerFirst, a nonprofit public benefit corporation, and is chief executive officer of ConsumerFirst Television. He chairs the California Health Policy and Data Advisory Commission and the State of California Health Information Committee. He also chairs the Consumer Experience Studies Committee of the Health Benefits Advisory Council for the California Public

Employees Retirement System. In addition, Mr. Kerr is executive producer and cohost of Health Upbeat, a television series providing information on health care quality, access, and costs to the public. Before joining ConsumerFirst, he held various positions at Bank of America, including vice president of government relations, manager of corporate health programs, and manager of benefits planning. He is the immediate past president of the California Business Group on Health. Mr. Kerr received a B.A. from the University of California, Davis, and an M.B.A. from the University of California, Berkeley.

James R. Kimmey

James R. Kimmey is vice president for health sciences and professor of public health at the St. Louis University Health Sciences Center, as well as professor of community and family medicine at the St. Louis University School of Medicine. In addition, Dr. Kimmey serves as chair and chief executive officer of SLUCare, the clinical services division of the university. He has taught at the University of Wisconsin, the Johns Hopkins University, New York University, and Columbia University. He was administrator of the Division of Health Policy and Planning of the state of Wisconsin and executive director of the American Public Health Association in New York and Washington State. Dr. Kimmey served as president of the American Health Planning Association (1980-81) and as a member of its board of directors. Former editor of *Health Planning Memorandum* and managing editor of the *American Journal of Public Health*, he has written extensively on health planning and other health policy topics. Dr. Kimmey received B.S., M.S., and M.D. degrees from the University of Wisconsin and an M.P.H. from the University of California, Berkeley.

Judith R. Lave

Judith R. Lave is professor of health economics and codirector of the Center for Research on Health Care at the University of Pittsburgh. Her primary academic appointment is in the Graduate School of Public Health, but she holds secondary appointments in the Department of Psychiatry, Department of Economics, and the Katz Graduate School of Business. She is a member of the research study section of the Agency for Health Care Policy and

Research and of the Institute of Medicine's report review committee. Formerly, Dr. Lave was a faculty member at Carnegie-Mellon University. At the Department of Health and Human Services, she was director of the Division of Economic and Quantitative Analysis in the Office of the Deputy Assistant Secretary and director of the Office of Research in the Health Care Financing Administration. A charter member of the Federal government's Senior Executive Service, Dr. Lave is also a member of the Institute of Medicine of the National Academy of Sciences and the National Academy of Social Insurance. She is a past president of the Association for Health Services Research and the Foundation for Health Services Research. In addition, Dr. Lave chaired the technical panel on health and was a member of the expert panel on income and health care for the Advisory Council on Social Security. She serves on the editorial boards of both the *Journal of Health Politics, Policy and Law* and the Health Administration Press. Dr. Lave has served as a consultant to private and public agencies in the United States and Canada. She received a B.A. from Queens University in Canada, from which she also holds an honorary LL.D., and a Ph.D. in economics from Harvard University.

Hugh W. Long

Hugh W. Long is associate professor of health systems management at the Tulane University School of Public Health and Tropical Medicine. He also holds appointments with Tulane's Freeman School of Business, School of Law, and Graduate Faculty. Dr. Long has taught at Yale University, Stanford University, San Jose State University, and Ohio State University. He is a member of the Medicare Geographic Classification Review Board. Dr. Long has served as a witness and ad hoc adviser on health care financing to the U.S. House of Representatives' Committee on Ways and Means and to the U.S. Senate Committee on Finance. He has written numerous articles on health care financing and management and serves on the editorial board of *Decisions in Imaging Economics*. Dr. Long is the faculty director of Tulane's Master of Medical Management degree program for physicians. He is a member of the Louisiana bar. Dr. Long received a B.A. from Ohio State University, an M.B.A. and a Ph.D. in business administration and finance from Stanford University, and a J.D. from the Tulane University School of Law.

Robert J. Myers

Robert J. Myers was chief actuary of the Social Security Administration from 1947 to 1970 and deputy commissioner of Social Security from 1981 to 1982. Currently, he is a member of the Committee of Actuaries of the United Nations Joint Staff Pension Fund, as well as president of the International Fisheries Commissions Pension Society. A trustee for several organizations, including the investment program (mutual funds) of the American Association of Retired Persons, Dr. Myers also serves on the board of advisers of Studies on Smoking. An active participant in retirement and pension plan issues, Dr. Myers chaired the Commission on Railroad Retirement Reform (1988-90) and the Railroad Unemployment Compensation Committee (1983-85). He served on the Commission on the Social Security "Notch" Issue (1993-94) and was executive director of the National Commission on Social Security Reform (1982-83). In addition, Dr. Myers has served as an actuarial consultant to various congressional committees, as a technical adviser on Social Security and pension programs to numerous foreign countries, and as president of both the American Academy of Actuaries and the Society of Actuaries. He has published widely on topics related to Social Security and retirement, and is professor emeritus at Temple University. He received a B.S. degree from Lehigh University, an M.S. degree from the University of Iowa, and honorary degrees from Lehigh University and Muhlenberg College.

Donald R. Oder

Donald R. Oder is executive vice president and chief operating officer of Rush-Presbyterian-St. Luke's Medical Center in Chicago, where he formerly was senior vice president. Before that, he was audit manager with Arthur Andersen & Co. in Chicago. Mr. Oder has held various academic appointments and currently is a professor in the Department of Health Systems Management at the Rush University College of Health Sciences. He is a member of and has held leadership positions in several professional associations, including the American College of Healthcare Executives, the American Hospital Association, the Illinois Hospital Association, Voluntary Hospitals of America, the American Institute of Certified Public Accountants, and the Illinois C.P.A. Society. He has served

on the board of directors of the Better Business Bureau of Metropolitan Chicago, Inc., and on the occupational health committee of the Chicago Association of Commerce and Industry. Mr. Oder received a B.S. from Wichita State University, a C.P.A. certificate from the University of Illinois, and an M.B.A. from the University of Chicago.

Glenda Rosenbloom

Glenda Rosenbloom has been vice president of prospective payment for American Medical International since 1983. Previously, she was health care consulting manager at Ernst & Whinney, where she was responsible for training hospital personnel implementing the Medicare prospective payment system. From 1972 to 1982, Ms. Rosenbloom was senior director for Medicare provider payment at the Blue Cross Blue Shield Association. Before that, she was audit supervisor at Peat, Marwick, Mitchell. She cochaired the Medicare Technical Advisory Group, which includes senior officials from the Health Care Financing Administration, the hospital industry, peer review organizations, and fiscal intermediaries. Ms. Rosenbloom served on the board of the Federation of American Health Systems, chaired its legislative committee, and was vice chair of its health care financing committee. She received a B.S. from the University of Illinois and is a certified public accountant.

J. Michael Sadaj

J. Michael Sadaj is a physician in private practice and a member of Rocky Mountain Clinic in Butte, Montana, where he specializes in internal medicine and pulmonary diseases. He is vice president and treasurer of the Montana Physicians Organization's medical service organization. He has served as secretary-treasurer, vice president, and president of St. James Community Hospital medical staff, as well as chief of the Department of Medicine, and is currently chairman of the credentialing committee. From 1979 to 1990, Dr. Sadaj was medical director of respiratory therapy and the pulmonary laboratory at St. James. For several years, he has served on the Occupational Diseases Board of the state of Montana. A past president of the Montana Medical Association (1988-89), Dr. Sadaj was a member of the executive committee from 1985 to 1995. In addition, he has served as a delegate to the American Medical Association

Resident Physician Section, Young Physician Section, and the House of Delegates, and from 1977 to 1979, was the resident member on the organization's Council on Constitution and Bylaws. Dr. Sadaj is a founding member of the board of directors of the Montana Professional Assistance Program and was a member of the Rural Physician Retention Trust Fund Advisory Board. In 1984, he was elected to the Butte-Silver Bow Government Study Commission. From 1974 to 1979, Dr. Sadaj was a resident in internal medicine and a fellow in pulmonary diseases at the University of Nebraska Medical Center. He received B.S. and M.D. degrees from the University of Nebraska.

Gerald M. Shea

Gerald M. Shea is assistant to the president for government affairs of the American Federation of Labor-Congress of Industrial Organizations. Previously, he has served as executive assistant to the president, executive assistant to the secretary-treasurer, and director of the employee benefits department of the A.F.L.-C.I.O., as well as head of the A.F.L.-C.I.O.'s health care reform campaign. His prior experience includes 12 years with the national office of the Service Employees International Union, where he held various positions, including assistant to the president for government affairs and health care division director. Before that, he was executive director and business manager of two local union offices. Mr. Shea is a member of the Advisory Council on Social Security. He received a B.A. from Boston College.

Roxane B. Spitzer

Roxane B. Spitzer is professor and associate dean for Practice Management at Vanderbilt University School of Nursing, professor of management at the Owen School of Vanderbilt, and executive director of University Community Health Systems. Previously, she was vice president of managed care at MEDICUS Systems. She also has been corporate vice president of St. Joseph Health System in Orange, California, and chief operating officer of the Good Samaritan Hospital in Los Angeles. She holds various professorships at Texas Tech University Health Sciences Center; University of Southern California; University of California, Los Angeles; and Vanderbilt University. From 1981 to 1988, Dr. Spitzer was vice president, patient care services, at

Cedars-Sinai Medical Center. Previously, she was director of nursing and practiced nursing in both inpatient and public health settings. She is a fellow of the American Academy of Nursing, a diplomate of the American College of Healthcare Executives, and serves on many other boards. Dr. Spitzer has written and spoken extensively on such issues as managing nonprofit organizations, cost containment, quality and productivity, nursing in the 1990s, and strategic management and leadership. She received a B.S. from Adelphi University, an M.A. in nursing service administration from Columbia University, and both an M.A. in management and an M.B.A. from Claremont Graduate School. Dr. Spitzer holds a Ph.D. in management from the Peter Drucker Management Center, Claremont Graduate School.

James R. Tallon Jr.

James R. Tallon Jr. is president of the United Hospital Fund of New York. He also chairs the Kaiser Commission on the Future of Medicaid and is a visiting lecturer at the Harvard University School of Public Health. In addition, he is a member of the board of commissioners of the Joint Commission on the Accreditation of Healthcare Organizations. Prior to joining the United Hospital Fund, he was the majority leader of the New York State Assembly, where he served for 19 years beginning in 1975. Mr. Tallon was a member of the executive committee of the National Academy for State Health Policy and served as liaison to the President's Task Force on Health Care Reform from the National Conference of State Legislatures. He also was a member of the Governor's Health Care Advisory Board's Task Force on the President's Health Care Plan in New York and chaired

the committee on Medicaid of the Health Policy Agenda for the American People. Before his election to the Assembly, Mr. Tallon was the executive director of the NY-PENN Health Planning Council, one of New York's eight regional health planning agencies. Mr. Tallon received a B.A. from Syracuse University and completed graduate work at the Maxwell School of Citizenship and Public Affairs. He received an M.A. from Boston University.

Jae L. Wittlich

Jae L. Wittlich is president and chief operating officer, group operations, CNA Insurance Companies. He also served as vice president of the group benefits department from 1985 to 1990 and as vice president of the group operations division from 1977 to 1985. Before joining CNA Insurance, Mr. Wittlich was with Allstate for 12 years, most recently as assistant vice president of group life and health operations. He is currently vice chairman of the board of directors of the Health Insurance Association of America. Besides being a member of the executive committee and board of directors of the Association of Private Pension and Welfare Plans, he serves on the boards of directors of AmeriChoice Corporation; the Foundation for Health Enhancement; Managed Healthcare Systems of New York; and Private Healthcare Systems, Inc. In addition, Mr. Wittlich has served on many other industry association committees and lectured frequently on health care topics. He received the 1990 Health Insurance Association of America's Founders Medal. Mr. Wittlich is a fellow of the Society of Actuaries and a member of the American Academy of Actuaries. He holds B.A. and M.A. degrees from the University of Michigan.



Appendix C. Statutory Mandate of the Commission

The Congress established the Prospective Payment Assessment Commission (ProPAC) in Public Law 98-21 (the Social Security Amendments of 1983) on April 20, 1983. The current responsibilities of ProPAC are set forth in sections 1862(a) and 1886 of the Social Security Act. Further responsibilities are set forth in various Acts and conferences reports. Below are the passages of the relevant legislative sources, as amended through 1994.

Section 1886(d) of the Social Security Act

(4)(C)(i) The Secretary shall adjust the classifications and weighting factors established under subparagraphs (A) and (B) [DRG classifications], for discharges in fiscal year 1988 and at least annually thereafter, to reflect changes in treatment patterns, technology, and other factors which may change the relative use of hospital resources.

(ii) For discharges in fiscal year 1990, the Secretary shall reduce the weighting factor for each diagnosis-related group by 1.22 percent.

(iii) Any such adjustment under clause (i) for discharges in a fiscal year (beginning with fiscal year 1991) shall be made in a manner that assures that the aggregate payments under this subsection for discharges in the fiscal year are not greater or less than those that would have been made for discharges in the year without such adjustment.

(iv) The Secretary shall include recommendations with respect to adjustments to weighting factors under clause (i) in the annual report to Congress required under subsection (e)(3)(B).

Section 1886(e)(2) through (6) of the Social Security Act

(2)(A) The Director of the Congressional Office of Technology Assessment (hereinafter in this subsection referred to as the "Director" and the "Office," respectively) shall provide for appointment of a Prospective Payment Assessment Commission (hereinafter in this subsection referred to

as the "Commission"), to be composed of independent experts appointed by the Director (without regard to the provisions of title 5, United States Code, governing appointments in the competitive service). The Commission shall review the applicable percentage increase factor described in subsection (b)(3)(B) and make recommendations to the [Congress] on the appropriate percentage change which should be effected for hospital inpatient discharges under subsections (b) and (d) for fiscal years beginning with fiscal year 1986. In making its recommendations, the Commission shall take into account changes in the hospital market-basket described in subsection (b)(3)(B), hospital productivity, technological and scientific advances, the quality of health care provided in hospitals (including the quality and skill level of professional nursing required to maintain quality care), and long-term cost-effectiveness in the provision of inpatient hospital services.

(B) In order to promote the efficient and effective delivery of high-quality health care services, the Commission shall, in addition to carrying out its functions under subparagraph (A), study and make recommendations for each fiscal year regarding changes in each existing reimbursement policy under this title under which payments to an institution are based upon prospectively determined rates and the development of new institutional reimbursement policies under this title, including recommendations related to payments during such fiscal year under the prospective payment system established under this section for determining payments for the operating costs of inpatient hospital services, including changes in the number of diagnosis-related groups used to classify inpatient hospital discharges under subsection (d), adjustments to such groups to reflect severity of illness, and changes in the methods by which hospitals are reimbursed for capital-related costs, together with general recommendations on the effectiveness and quality of health care delivery systems in the United States and the effects on such systems of institutional reimbursements under this title.

(C) By not later than June 1 of each year, the Commission shall submit a report to Congress containing an examination of issues affecting health care delivery in the United States, including issues relating to—

- (i) trends in health care costs;
- (ii) the financial condition of hospitals and the effect of the level of payments made to hospitals under this title on such condition;
- (iii) trends in the use of health care services; and
- (iv) new methods used by employers, insurers, and others to constrain growth in health care costs.

(3)(A) The Commission, not later than March 1 before the beginning of each fiscal year (beginning with fiscal year 1986) shall report its recommendations to Congress on an appropriate change factor which should be used for inpatient hospital services in that fiscal year, together with its general recommendations under paragraph (2)(B) regarding the effectiveness and quality of health care delivery systems in the United States.

(B) The Secretary, not later than April 1, 1987, for fiscal year 1988 and not later than March 1, before the beginning of each fiscal year (beginning with fiscal year 1989), shall report to the Congress the Secretary's initial estimate of the percentage change that the Secretary will recommend under paragraph (4) with respect to that fiscal year.

(4)(A) Taking into consideration the recommendations of the Commission, the Secretary shall recommend for each fiscal year (beginning with fiscal year 1988) an appropriate change factor for inpatient hospital services for discharges in that fiscal year which will take into account amounts necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality. The appropriate change factor may be different for all large urban subsection (d) hospitals, other urban subsection (d) hospitals, urban subsection (d) Puerto Rico hospitals, rural subsection (d) hospitals, and rural subsection (d) Puerto Rican hospitals, and all other hospitals and units not paid under subsection (d), and may vary among such other hospitals and units.

(B) In addition to the recommendation made under subparagraph (A), the Secretary shall, taking into consideration the recommendations of the Commission under paragraph (2)(B), recommend for each fiscal year (beginning with fiscal year 1992) other appropriate changes in each existing reimbursement policy under this title under which payments to an institution are based upon prospectively determined rates.

(5) The Secretary shall cause to have published in the *Federal Register*, not later than—

(A) the May 1 before each fiscal year (beginning with fiscal year 1986), the Secretary's proposed recommendations under paragraph (4) for that fiscal year for public comment, and

(B) the September 1 before such fiscal year after such consideration of public comment on the proposal as is feasible in the time available, the Secretary's final recommendations under such paragraph for that year.

The Secretary shall include in the publication referred to in subparagraph (A) for a fiscal year the report of the Commission's recommendations submitted under paragraph (3) for that fiscal year. To the extent that the Secretary's recommendations under paragraph (4) differ from the Commission's recommendations for that fiscal year, the Secretary shall include in the publication referred to in subparagraph (A) an explanation of the Secretary's grounds for not following the Commission's recommendations.

(6)(A) The Commission shall consist of 17 individuals. Members of the Commission shall first be appointed no later than April 1, 1984, for a term of three years, except that the Director may provide initially for such shorter terms as will insure that (on a continuing basis) the terms of no more than seven members may expire in any one year.

(B) The membership of the Commission shall include individuals with national recognition for their expertise in health economics, health facility management, reimbursement of health facilities or other providers of services which reflect the scope of the Commission's responsibilities, and other related fields, who provide a mix of different professional, broad geographic representation, and a balance between urban and rural representatives, including physicians and registered professional

nurses, employers, third party payors, individuals skilled in the conduct and interpretation of biomedical, health services, and health economics research, and individuals having expertise in the research and development of technological and scientific advances in health care.

(C) Subject to such review as the Office deems necessary to assure the efficient administration of the Commission, the Commission may—

(i) employ and fix the compensation of an Executive Director (subject to the approval of the Director of the Office) and such other personnel (not to exceed 25) as may be necessary to carry out its duties (without regard to the provisions of the title 5, United States Code, governing appointments in the competitive service);

(ii) seek such assistance and support as may be required in the performance of its duties from appropriate Federal departments and agencies;

(iii) enter into contracts or make other arrangements, as may be necessary for the conduct of the work of the Commission (without regard to section 3709 of the Revised Statutes (41 U.S.C. 5));

(iv) make advance, progress, and other payments which relate to the work of the Commission;

(v) provide transportation and subsistence for persons serving without compensation; and

(vi) prescribe such rules and regulations as it deems necessary with respect to the internal organization and operation of the Commission.

Section 10(a)(1) of the Federal Advisory Committee Act shall not apply to any portion of a Commission meeting if the Commission, by majority vote, determines that such portion of such meeting should be closed.

(D) While serving on the business of the Commission (including travel-time), a member of the Commission shall be entitled to compensation at the per diem equivalent of the rate provided for level IV of the Executive Schedule under section 5315 of title 5, United States Code; and while so serving away from home and his regular place of business, a member may be allowed travel

expenses, as authorized by the Chairman of the Commission. Physicians serving as personnel of the Commission may be provided a physician comparability allowance by the Commission in the same manner as Government physicians may be provided such an allowance by an agency under section 5948 of title 5, United States Code, and for such purpose subsection (i) of such section shall apply to the Commission in the same manner as it applies to the Tennessee Valley Authority. For purposes of pay (other than pay of members of the Commission) and employment benefits, rights, and privileges, all personnel of the Commission shall be treated as if they were employees of the United States Senate.

(E) In order to identify medically appropriate patterns of health resources use in accordance with paragraph (2), the Commission shall collect and assess information on medical and surgical procedures and services, including information on regional variations of medical practice and lengths of hospitalization and on other patient-care data, giving special attention to treatment patterns for conditions which appear to involve excessively costly or inappropriate services not adding to the quality of care provided. In order to assess the safety, efficacy, and cost-effectiveness of new and existing medical and surgical procedures, the Commission shall, in coordination to the extent possible with the Secretary, collect and assess factual information, giving special attention to the needs of updating existing diagnosis-related groups, establishing new diagnosis-related groups, and making recommendations on relative weighting factors for such groups to reflect appropriate differences in resource consumption in delivering safe, efficacious, and cost-effective care. In collecting and assessing information, the Commission shall—

(i) utilize existing information, both published and unpublished, where possible, collected and assessed either by its own staff or under other arrangements made in accordance with this paragraph;

(ii) carry out, award grants or contracts for, original research and experimentation, including clinical research, where existing information is inadequate for the development of useful and valid guidelines by the Commission; and

(iii) adopt procedures allowing any interested party to submit information with respect to medical

and surgical procedures and services (including new practices, such as the use of new technologies and treatment modalities), which information the Commission shall consider in making reports and recommendations to the Secretary and Congress.

(F) The Commission shall have access to such relevant information and data as may be available from appropriate Federal agencies and shall assure that its activities, especially the conduct of original research and medical studies, are coordinated with the activities of Federal agencies.

(G)(i) The Office shall have unrestricted access to all deliberations, records, and data of the Commission, immediately upon its request.

(ii) In order to carry out its duties under this paragraph, the Office is authorized to expend reasonable and necessary funds as mutually agreed upon by the Office and the Commission. The Office shall be reimbursed for such funds by the Commission from the appropriations made with respect to the Commission.

(H) The Commission shall be subject to periodic audit by the General Accounting Office.

(I)(i) There are authorized to be appropriated such sums as may be necessary to carry out the provision of this paragraph.

(ii) Eighty-five percent of such appropriation shall be payable from the Federal Hospital Insurance Trust Fund, and 15 percent of such appropriation shall be payable from the Federal Supplementary Medical Insurance Trust Fund.

(J) The Commission shall submit requests for appropriations in the same manner as the Office submits requests for appropriations, but amounts appropriated for the Commission shall be separate from amounts appropriated for the Office.

Section 1862(a) of the Social Security Act

(a) Notwithstanding any other provision of this title, no payment may be made under part A or part B for any expenses incurred for items or services—

(1)(A) which, except for items and services described in a succeeding subparagraph, are not reasonable and necessary for the diagnosis or treat-

ment of illness or injury or to improve the functioning of a malformed body member,

(B) in the case of items and services described in section 1861(s)(10), which are not reasonable and necessary for the prevention of illness,

(C) in the case of hospice care, which are not reasonable and necessary for the palliation or management of terminal illness,

(D) in the case of clinical care items and services provided with the concurrence of the Secretary and with respect to research and experimentation conducted by, or under contract with, the Prospective Payment Assessment Commission or the Secretary, which are not reasonable and necessary to carry out the purposes of section 1886(e)(6), . . .

Section 1135(d) of the Social Security Act

(6)(A) The Secretary shall develop a model system for the payment for outpatient hospitals services other than ambulatory surgery.

(B) The Secretary shall submit to Congress a report on the model payment system under subparagraph (A) by January 1, 1991.

(7) The Secretary shall solicit the views of the Prospective Payment Assessment Commission in developing the systems under paragraphs (1) and (6), and shall include in the Secretary's reports under this subsection any views the Commission may submit with respect to such systems.

Section 9114 of the Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. 99-272

(a) Disclosure of Information.—The Secretary of Health and Human Services shall make available to the Prospective Payment Assessment Commission, the Congressional Budget Office, and the Congressional Research Service the most current information on the payments being made under section 1886 of the Social Security Act to individual hospitals. Such information shall be made available in a manner that permits examination of the impact of such section on such hospitals.

(b) Confidentiality.—Information disclosed under subsection (a) shall be treated as confidential

and shall not be subject to further disclosure in a manner that permits the identification of individual hospitals.

**Section 6003(i) of the Omnibus Budget Reconciliation Act of 1989, Pub. L. 101-239:
Legislative Proposal Eliminating Separate
Average Standardized Amounts**

(1) In General.—The Secretary of Health and Human Services (hereafter referred to as the “Secretary”) shall design a legislative proposal eliminating the system of determining separate standardized amounts for subsection (d) hospitals (as defined in section 1886(d)(1)(B) of the Social Security Act) classified as being located in large urban, other urban, or rural areas under section 1886(d)(2)(D) of such Act, and shall include in such proposal the following—

(A) A transition period beginning in fiscal year 1992 during which a single rate for determining payment to hospitals in all areas shall be phased in with such single rate to be completely in effect by fiscal year 1995.

(B) Recommendations, where appropriate, for modifying or maintaining additional payments or adjustments under title XVIII of the Social Security Act for teaching hospitals, rural referral centers, sole community hospitals, disproportionate share hospitals, and outlier cases, and for creating additional payments or adjustments where deemed appropriate by the Secretary.

(C) Recommendations with respect to recalculating standardized amounts to reflect information from more recent cost reporting periods.

(D) Recommendations, where appropriate, for modifying reimbursement for hospitals that are not subsection (d) hospitals under title XVIII of such Act.

(E) A recommendation for a methodology to reflect the severity of illness of different patients within the same diagnosis related group (as determined in section 1886(d)(4)(B) of such Act).

(2) Report to Congress and ProPAC.—(A) Not later than October 1, 1990, the Secretary shall

submit the proposal described in paragraph (1) and an accompanying analysis of the impact of the proposed elimination of separate average standardized amounts on various categories of hospitals to Congress and the Prospective Payment Assessment Commission.

(B) Not later than February 1, 1991, the Prospective Payment Assessment Commission and the Director of the Congressional Budget Office shall each prepare and submit to Congress a report analyzing the legislative proposal submitted under subparagraph (A), and shall include in such report an analysis of the probable impact of such legislation on hospitals participating in the Medicare program.

**Section 6003(j) of the Omnibus Budget Reconciliation Act of 1989, Pub. L. 101-239:
ProPac Study of Payments to Rural Sole
Community Hospitals and Small Rural
Hospitals**

(1) Study.— The Prospective Payment Assessment Commission (hereinafter referred to as the “Commission”) shall conduct a study of the feasibility and desirability of—

(A) using a cost-based reimbursement system to determine the amount of payments to be made under the Medicare program to small rural hospitals and rural sole community hospitals for the operating costs of inpatient hospital services;

(B) developing and applying alternative definitions of market share for use in determining the eligibility of hospitals for classification as sole community hospitals under section 1886(d)(5) of the Social Security Act; and

(C) developing and applying a method for accounting for decreases in the number of inpatients served in determining payment to small rural hospitals under section 1886(d) of the Social Security Act for the operating costs of inpatient hospital services.

(2) Report.—By not later than May 1, 1990, the Commission shall submit a report to Congress on the study conducted under paragraph (1).

Section 6011 of the Omnibus Budget Reconciliation Act of 1989, Pub. L. 101-239
Pass Through Payments for Hemophilia Inpatients

(a) Pass Through Payment for Hemophilia Inpatients.—The second sentence of section 1886(a)(4) of the Social Security Act . . . is amended to read as follows—

For purposes of this section, the term “operating cost of inpatient hospital services” . . . does not include . . . costs with respect to administering blood clotting factors to individual with hemophilia.

(b) Determining Payment Amount.—The Secretary of Health and Human Services shall determine the amount of payment made to hospitals under part A of title XVIII of the Social Security Act for the costs of administering blood clotting factors to individuals with hemophilia by multiplying a predetermined price per unit of blood clotting factor (determined in consultation with the Prospective Payment Assessment Commission) by the number of units provided to the individual.

(c) Recommendations on Payments.—The Prospective Payment Assessment Commission and the Health Care Financing Administration shall develop recommendations with respect to payments under part A of title XVIII of the Social Security Act for the costs of administering blood clotting factors to individuals with hemophilia, and shall submit such recommendations to Congress not later than 18 months after the date of enactment of this Act.

Section 6137 of the Omnibus Budget Reconciliation Act of 1989, Pub. L. 101-239:
ProPAC Study of Payments for Services in Hospital Outpatient Departments

(a) In General.—The Prospective Payment Assessment Commission shall conduct a study on payment under title XVIII of the Social Security Act for hospital outpatient services. Such study shall include an examination of—

(1) the sources of growth in spending for hospital outpatient services;

(2) the differences between the costs of delivering services in a hospital outpatient department as opposed to providing similar services in other appropriate settings (including ambulatory surgery centers and physician offices);

(3) the effects on outpatient hospital costs of the step-down method used to allocate hospital capital between inpatient and outpatient departments and the extent to which hospital outpatient costs were affected by the implementation of the prospective payment system of payment for inpatient hospital services and by increased review of such services by peer review organizations; and

(4) alternative methods for reimbursing hospitals for services in outpatient departments under the Medicare program, including prospective payment methods, fee schedules, and other such methods as the Commission may consider appropriate.

(b) Reports.—(1) By not later than July 1, 1990, the Commission shall submit a report to Congress on the study conducted under section (a) with respect to the portions of the study described in paragraphs (1), (2), and (3) of such subsection, and shall include in the report such recommendations as the Commission deems appropriate.

(2) By not later than March 1, 1991, the Commission shall submit a report to Congress on the study conducted under subsection (a) with respect to the portion of the study described in paragraph (4) of such subsection, and shall include such recommendations as the Commission deems appropriate.

Section 4002(d)(2) of the Omnibus Budget Reconciliation Act of 1990, Pub. L. 101-508:
Study of the Area Wage Index Adjustments Based on Professional Occupational Component

(A) Study.—The Prospective Payment Assessment Commission shall examine available data from States and other sources measuring earnings and paid hours of employment of hospital workers by occupational category, and shall include in such examination an analysis of the impact of variation in occupational mix on the computation of the area wage index determined under section 1886(d)(3)(E) of the Social Security Act.

(B) Report to Congress.—In its March 1991 report, the Commission shall include recommendations regarding the feasibility and desirability of modifying such area wage index to take into account occupational mix, including variations in occupational mix resulting from differences in State codes and requirements.

Section 4002(g)(4) of the Omnibus Budget Reconciliation Act of 1990, Pub. L. 101-508: ProPAC Study of Medicaid Payments to Hospitals

(A) Study.—The Prospective Payment Assessment Commission shall conduct a study of hospital payment rates under State plans for medical assistance under title XIX of the Social Security Act, and shall specifically examine in such study the relationship between payments under such plans and payments made to hospitals under title XVIII of such Act, and the financial condition of hospitals receiving payments under such plans, with particular attention to hospitals in urban areas which treat large number of individuals eligible for medical assistance under title XIX of such Act and other low-income individuals.

(B) Report.—By not later than October 1, 1991, the Commission shall submit a report to Congress on the study conducted under subparagraph (A) and shall include in such report such recommendations relating to requirements for payments to hospitals under title XIX of such Act as the Commission deems appropriate.

Section 4005(b) of the Omnibus Budget Reconciliation Act of 1990, Pub. L. 101-508: Development of National Prospective Payment Rates for Current Non-PPS Hospitals

(1) Development of Proposal.—The Secretary of Health and Human Services shall develop a proposal to modify the current system under which hospitals that are not subsection (d) hospitals (as defined in section 1886(d)(1)(B) of the Social Security Act) receive payment for the operating and capital-related costs of inpatient hospital services under part A of the Medicare program or a proposal to replace such system with a system under which such payments would be made on the

basis of nationally-determined average standardized amounts. In developing any proposal under this paragraph to replace the current system with a prospective payment system, the Secretary shall—

(A) take into consideration the need to provide for appropriate limits on increases in expenditures under the Medicare program;

(B) provide for adjustments to prospectively determined rates to account for changes in a hospital's case mix, severity of illness of patients, volume of cases, and the development of new technologies and standards of medical practice;

(C) take into consideration the need to increase the payment otherwise made under such system in the case of services provided to patients whose length of stay or costs of treatment greatly exceed the length of stay or cost of treatment provided for under the applicable prospectively determined payment rate;

(D) take into consideration the need to adjust payments under the system to take into account factors such as a disproportionate share of low-income patients, costs related to graduate medical education programs, differences in wages and wage-related costs among hospitals located in various geographic areas, and other factors the Secretary considers appropriate, and

(E) provide for the appropriate allocation of operating and capital-related costs of hospitals not subject to the new prospective payment system and distinct units of such hospitals that would be paid under such system.

(2) Report.—(A) By not later than April 1, 1992, the Secretary shall submit the proposal developed under paragraph (1) to the Committee on Finance of the Senate and the Committee on Ways and Means of the House of Representatives.

(B) By not later than June 1, 1992, the Prospective Payment Assessment Commission shall submit an analysis of and comments on the proposal developed under paragraph (1) to the Committee on Finance of the Senate and the Committee on Ways and Means of the House of Representatives.

Section 4008(k) of the Omnibus Budget Reconciliation Act of 1990, Pub. L. 101-508: Prospective Payment System for Skilled Nursing Facilities

(1) Development of Proposal.—The Secretary of Health and Human Services shall develop a proposal to modify the current system under which skilled nursing facilities receive payment for extended care services under part A of the Medicare program or a proposal to replace such system with a system under which such payments would be made on the basis of prospectively determined rates. In developing any proposal under this paragraph to replace the current system with a prospective payment system, the Secretary shall—

(A) take into consideration the need to provide for appropriate limits on increases in expenditures under the Medicare program without jeopardizing access to extended care services for individuals unable to care for themselves;

(B) provide for adjustments to prospectively determined rates to account for changes in a facility's case mix, volume of cases, and the development of new technologies and standards of medical practice;

(C) take into consideration the need to increase the payment otherwise made under such system in the case of services provided to patients whose length of stay or costs of treatment greatly exceed the length of stay or cost of treatment provided for under the applicable prospectively determined payment rate;

(D) take into consideration the need to adjust payments under the system to take into account factors such as a disproportionate share of low-income patients, differences in wages and wage-related costs among facilities located in various geographic areas, and other factors the Secretary considers appropriate; and

(E) take into consideration the appropriateness of classifying patients and payments upon functional disability, cognitive impairment, and other patient characteristics.

(2) Reports.—(A) By not later than April 1, 1991, the Secretary (acting through the Administrator of

the Health Care Financing Administration) shall submit any research studies to be used in developing the proposal under paragraph (1) to the Committee on Finance of the Senate and the Committee on Ways and Means of the House of Representatives.

(B) By not later than September 1, 1991, the Secretary shall submit the proposal developed under paragraph (1) to the Committee on Finance of the Senate and the Committee on Ways and Means of the House of Representatives.

(C) By not later than March 1, 1992, the Prospective Payment Assessment Commission shall submit an analysis of and comments on the proposal developed under paragraph (1) to the Committee on Finance of the Senate and the Committee on Ways and Means of the House of Representatives.

Section 4151(b)(2) of the Omnibus Budget Reconciliation Act of 1990, Pub. L. 101-508: Prospective Payment System for Hospital Outpatient Services

(A) Development of Proposal.—The Secretary of Health and Human Services shall develop a proposal to replace the current system under which payment is made for hospital outpatient services under title XVIII of the Social Security Act with a system under which such payments would be made on the basis of prospectively determined rates. In developing any proposal under this paragraph, the Secretary shall consider—

(i) the need to provide for appropriate limits on increases in expenditures under the Medicare program;

(ii) the need to adjust prospectively determined rates to account for changes in a hospital's outpatient case mix, severity of illness of patients, volume of cases, and the development of new technologies and standards of medical practice;

(iii) providing hospitals with incentives to control the costs of providing outpatient services;

(iv) the feasibility and appropriateness of including payment for outpatient services not currently paid on a cost-related basis under the Medicare

program (including clinical diagnostic laboratory tests and dialysis services) in the system:

(v) the need to increase payments under the system to hospitals that treat a disproportionate share of low-income patients, teaching hospitals, and hospitals located in geographic areas with high wages and wage-related costs;

(vi) the feasibility and appropriateness of bundling services into larger units, such as episodes or visits, in establishing the basic unit for making payments under the system; and

(vii) the feasibility and appropriateness of varying payments under the system on the basis of whether services are provided in a free-standing or hospital-based facility.

(B) Reports.—(i) By not later than January 1, 1991, the Administrator of the Health Care Financing Administration shall submit research findings relating to prospective payments for hospital outpatient services to the Committee on Finance of the Senate and the Committees on Ways and Means and Energy and Commerce of the House of Representatives.

(ii) By not later than September 1, 1991, the Secretary shall submit the proposal developed under subparagraph (A) to such Committees.

(iii) By not later than March 1, 1992, the Prospective Payment Assessment Commission shall submit an analysis of and comments on the proposal developed under subparagraph (A) to such Committees.

Section 4201(b) of the Omnibus Budget Reconciliation Act of 1990, Pub. L. 101-508: ProPAC Study on ESRD Composite Rates

(1) In General.—(A) Study.—The Prospective Payment Assessment Commission (in this subsection referred to as the “Commission”) shall conduct a study to determine the costs and services and profits associated with various modalities of dialysis treatments provided to end stage renal disease patients provided under title XVIII of the Social Security Act.

(B) Recommendations.—Based on information collected for the study described in subparagraph

(A), the Commission shall make recommendations to Congress regarding the method or methods and the levels at which the payments made for the facility component of dialysis services by providers of service and renal dialysis facilities under title XVIII of the Social Security Act should be established for dialysis services furnished during fiscal year 1993 and the methodology to be used to update such payments for subsequent fiscal years. In making recommendations concerning the appropriate methodology the Commission shall consider—

(i) hemodialysis and other modalities of treatment,

(ii) the appropriate services to be included in such payments,

(iii) the adjustment factors to be incorporated including facility characteristics, such as hospital versus free-standing facilities, urban versus rural, size and mix of services,

(iv) adjustments for labor and non-labor costs,

(v) comparative profit margins for all types of renal dialysis providers of service and renal dialysis facilities,

(vi) adjustments for patient complexity, such as age, diagnosis, case mix, and pediatric services, and

(vii) efficient costs related to high quality of care and positive outcomes for all treatment modalities.

(2) Report.—Not later than June 1, 1992, the Commission shall submit a report to the Committee on Finance of the Senate, and the Committees on Ways and Means and Energy and Commerce of the House of Representatives on the study conducted under paragraph (1)(A) and shall include in the report the recommendations described in paragraph (1)(B), taking into account the factors described in paragraph (1)(B).

(3) Annual Report.—The Commission, not later than March 1 before the beginning of each fiscal year (beginning with fiscal year 1993) shall report its recommendations to the Committee on Finance of the Senate and the Committees on Ways and

Means and Energy and Commerce of the House of Representatives on an appropriate change factor which should be used for updating payments for services rendered in that fiscal year. The Commission in making such report to Congress shall consider conclusions and recommendations available from the Institute of Medicine.

**Section 4207(c) of the Omnibus Budget Reconciliation Act of 1990, Pub. L. 101-508:
Development of Prospective Payment System for Home Health Services**

(1) Development of Proposal.—The Secretary of Health and Human Services shall develop a proposal to modify the current system under which payment is made for home health services under title XVIII of the Social Security Act or a proposal to replace such system with a system under which such payments would be made on the basis of prospectively determined rates. In developing any proposal under this paragraph to replace the current system with a prospective payment system, the Secretary shall—

(A) take into consideration the need to provide for appropriate limits on increases in expenditures under the Medicare program;

(B) provide for adjustments to prospectively determined rates to account for changes in a provider's case mix, severity of illness of patients, volume of cases, and the development of new technologies and standards of medical practice;

(C) take into consideration the need to increase the payment otherwise made under such system in the case of services provided to patients whose length of treatment or costs of treatment greatly exceed the length or cost of treatment provided for under the applicable prospectively determined payment rate;

(D) take into consideration the need to adjust payments under the system to take into account factors such as differences in wages and wage-related costs among agencies located in various geographic areas and other factors the Secretary considers appropriate; and

(E) analyze the feasibility and appropriateness of establishing the episode of illness as the basic unit for making payments under the system.

(2) Reports.—(A) By not later than April 1, 1993, the Secretary of Health and Human Services shall submit the research findings upon which the proposal described in paragraph (1) shall be based to the Committee on Finance of the Senate and the Committee on Ways and Means of the House of Representatives.

(B) By not later than September 1, 1993, the Secretary shall submit the proposal developed under paragraph (1) to the Committee on Finance of the Senate and the Committee on Ways and Means of the House of Representatives.

(C) By not later than March 1, 1994, the Prospective Payment Assessment Commission shall submit an analysis of and comments on the proposal developed under paragraph (1) to the Committee on Finance of the Senate and the Committee on Ways and Means of the House of Representatives.

**H.R. Rep. No. 964, 101st Cong., 1st Sess.
(1990)**

(Report of the Committee of Conferees, Pub. L. 101-508)

In performing this function [developing and modification of reimbursement policies], the conferees intend that ProPAC would include in its analysis and recommendations, proposals for changes in policies regarding: (1) payment for inner-city hospitals, including appropriate recognition of bad debt and charity care costs; (2) payment for rural hospitals including recommendations on appropriate responses to issues affecting access to health care services in rural areas; and (3) policies which help constrain the costs of health care to employers, including changes in Medicare and its payment policies which may affect other payers.

**S.R. Rep. No. 516, 101st Cong., 2nd Sess.
(1990)**

(Report of the Senate Committee on Appropriations, H.R. 5257)

The Committee, therefore, requests that ProPAC issue a report listing (1) the adjustments that have been made to PPS since its inception (for example changes in standardized amount, outlier pool, consideration of part-time labor); and (2) the amount of increased payments (taking inflation into

account) for PPS years 1-5 and what rural hospitals would have received if these adjustments had been in place from the system's beginning.

In addition, the Committee request that ProPAC in its 1991 report address in detail the impact of less-than-average patient volume on overhead costs and reimbursement, especially on small hospitals. This Committee remains concerned that the PPS system, which is based on averages, inherently is inappropriate to small-volume hospitals.

Given the history of inequitable inpatient payments and the widespread concern over new systems of outpatient payments, the Committee finds it is necessary to investigate whether outpatient payment systems also will be biased against smaller rural providers. The Committee requests that ProPAC in its 1991 report identify all potential outpatient payment biases against small rural hospitals, and recommend actions to correct them.

The Committee is concerned that the Federal Office of Rural Health Policy lacks essential resources such as computer capability in order to fulfill its statutory mandate to provide impact analyses of proposed Medicare and Medicaid regulations. The Committee instructs ProPAC to provide its resources to the Office of Rural Health Policy in order to facilitate these analyses. The Committee expects The Commission to provide technical assistance to the Office of Rural Health Policy.

The Committee urges ProPAC to continue to study the use of nurse practitioners and other non-physician providers in alternative settings to acute care and long-term institutional care.

Section 3(d) of the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991, Pub. L. 102-234: Study of Medicaid DSH Payment Adjustments

(1) In General.—The Prospective Payment Assessment Commission shall conduct a study concerning—

(A) the feasibility and desirability of establishing maximum and minimum payment adjustments under section 1923(c) of the Social Security Act for hospitals deemed disproportionate share hospitals under State medicaid plans, and

(B) criteria (other than criteria described in clause (i) or (ii) of section 1923(f)(1)(D) of such Act) that are appropriate for the designation of disproportionate share hospitals under section 1923 of such Act.

(2) Items Included In Study.—The Commission shall include in the study—

(A) a comparison of the payment adjustments for hospitals made under such section and the additional payments made under title XVIII of such Act for hospitals serving a significantly disproportionate number of low-income patients under the medicare program; and

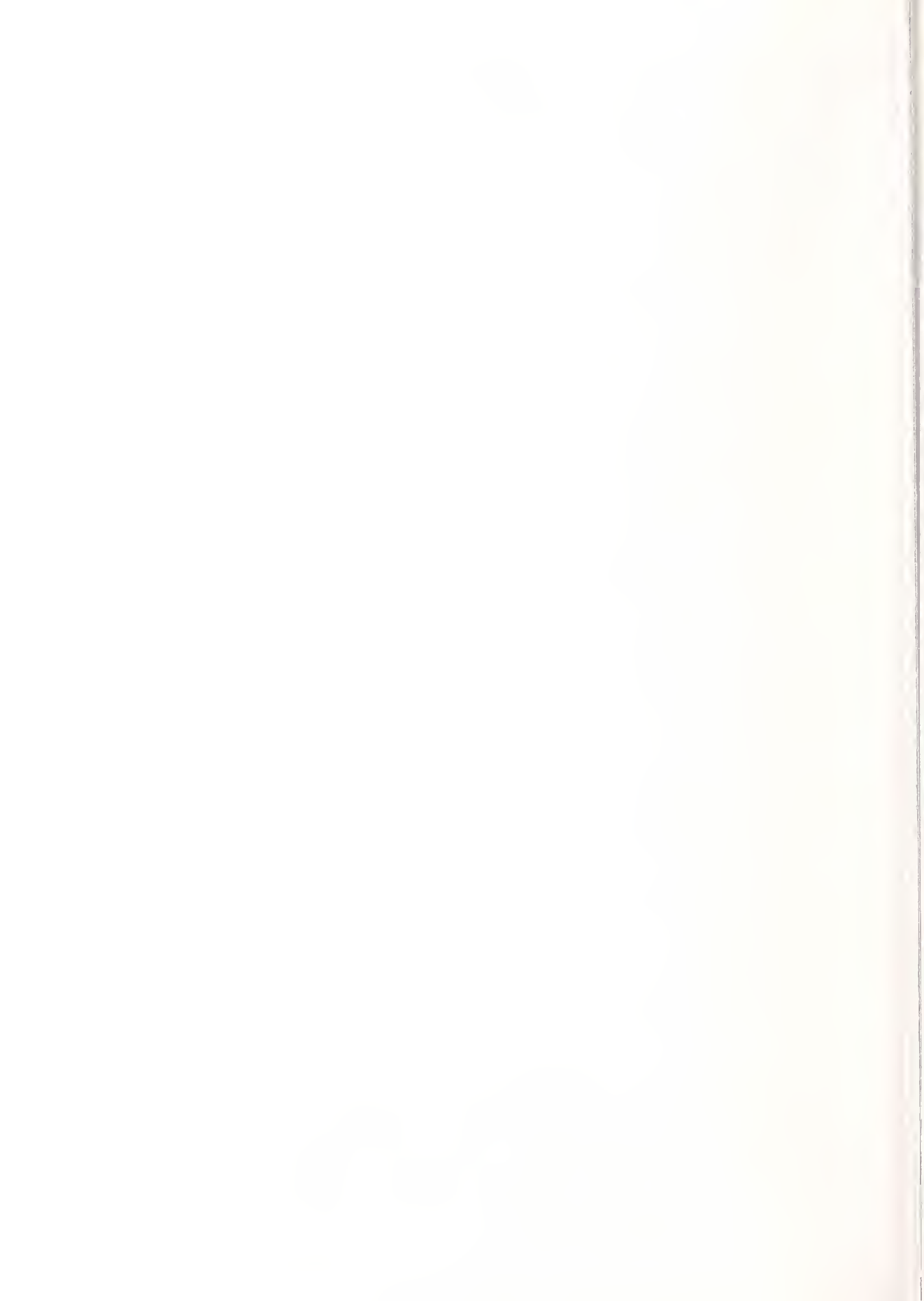
(B) an analysis of the effect the establishment of limits on such payment adjustments will have on the ability of the hospitals to be reimbursed for the resource costs incurred by the hospitals in treating individuals entitled to medical assistance under State medicaid plans and other low-income patients.

(3) Report.—Not later than January 1, 1994, the Commission shall submit a report on the study conducted under paragraph (1) to the Committee on Finance of the Senate and the Committee on Energy and Commerce of the House of Representatives. Such report shall include such recommendations respecting the designation of disproportionate share hospitals and the establishment of maximum and minimum payment adjustments for such hospitals under section 1923 of the Social Security Act as may be appropriate.

H.R. Rep. No. 103-213, 103rd Cong., 1st Sess. (1993)

(Report of the Conference Committee, Omnibus Budget Reconciliation Act of 1993, Pub. L. 103-66)

The conferees note that the Prospective Payment Assessment Commission has expressed concern that the Secretary's outlier policy penalizes hospitals that receive a large number of transfer cases. The conferees expect that the Commission will evaluate whether the changes in outlier policy required by this Act will be sufficient to reduce the risk of large losses on transfer cases for such hospitals and make recommendations regarding whether additional changes in payment methodology would be appropriate.



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